| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *MRKC-126222233* | *State:* | *Arkansas* |
| *Filing Company:* | *Markel Insurance Company* | *State Tracking Number:* | *42899* |
| *Company Tracking Number:* | *MISTM100-AR (07/09)* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.004 Short Term* |
| *Product Name:* | *Short Term Medical Insurance* | | |
| *Project Name/Number:* | *Short Term Medical Insurance/MISTM100-AR (07/09)* | | |

## Filing at a Glance

Company: Markel Insurance Company

| | | |
|---|---|---|
| Product Name: Short Term Medical Insurance | SERFF Tr Num: MRKC-126222233 | State: ArkansasLH |
| TOI: H16I Individual Health - Major Medical | SERFF Status: Closed | State Tr Num: 42899 |
| Sub-TOI: H16I.004 Short Term | Co Tr Num: MISTM100-AR (07/09) | State Status: Approved-Closed |
| Filing Type: Form | Co Status: | Reviewer(s): Rosalind Minor |
| | Authors: Carol Depuy, Sue Bogusz | Disposition Date: 07/13/2009 |
| | Date Submitted: 07/09/2009 | Disposition Status: Approved-Closed |

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Short Term Medical Insurance

Project Number: MISTM100-AR (07/09)

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 07/13/2009

Deemer Date:

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 04/19/2007

Domicile Status Comments: Approved as a group market in Illinois, our state of domicile.

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 07/13/2009

Corresponding Filing Tracking Number:

Filing Description:

We are submitting a revision to form MISTM100-AR in order to be in compliance with 23-79-1303, Coverage for Prostate Cancer Screening.

## Company and Contact

**Filing Contact Information**

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *MRKC-126222233* | *State:* | *Arkansas* |
| *Filing Company:* | *Markel Insurance Company* | *State Tracking Number:* | *42899* |
| *Company Tracking Number:* | *MISTM100-AR (07/09)* | | |
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| *Product Name:* | *Short Term Medical Insurance* | | |
| *Project Name/Number:* | *Short Term Medical Insurance/MISTM100-AR (07/09)* | | |

Bogusz Sue, Regulatory Compliance Assistant
184 Shuman Blvd
Naperville, IL 60563

sbogusz@markelcorp.com
(630) 778-7770 [Phone]
(804) 527-7915[FAX]

**Filing Company Information**

| | | |
|---|---|---|
| Markel Insurance Company | CoCode: 38970 | State of Domicile: Illinois |
| 4600 Cox Road | Group Code: 785 | Company Type: Property & Casualty |
| Glen Allen, VA 23060 | Group Name: | State ID Number: |
| (800) 431-1270 ext. [Phone] | FEIN Number: 36-3101262 | |

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| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *MRKC-126222233* | *State:* | *Arkansas* |
| *Filing Company:* | *Markel Insurance Company* | *State Tracking Number:* | *42899* |
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# Filing Fees

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $50.00 |
| Retaliatory? | Yes |
| Fee Explanation: | 1 form @ $50.00 |
| Per Company: | No |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---|---|---|
| Markel Insurance Company | $50.00 | 07/09/2009 | 29094736 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *MRKC-126222233* | *State:* | *Arkansas* |
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| *Project Name/Number:* | *Short Term Medical Insurance/MISTM100-AR (07/09)* | | |

# Correspondence Summary

### Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved-Closed | Rosalind Minor | 07/13/2009 | 07/13/2009 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *MRKC-126222233* | *State:* | *Arkansas* |
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# Disposition

Disposition Date: 07/13/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *MRKC-126222233* | *State:* | *Arkansas* |
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| Item Type | Item Name | Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Flesch Certification | Approved-Closed | Yes |
| **Supporting Document** | Application | Approved-Closed | Yes |
| **Supporting Document** | Health - Actuarial Justification | Approved-Closed | Yes |
| **Supporting Document** | Outline of Coverage | Approved-Closed | Yes |
| **Supporting Document** | Red-Lined Document Reflecting Changes | Approved-Closed | Yes |
| **Form** | Individual Policy, Short Term Medical Insurance | Approved-Closed | Yes |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *MRKC-126222233* | *State:* | *Arkansas* |
| *Filing Company:* | *Markel Insurance Company* | *State Tracking Number:* | *42899* |
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# Form Schedule

**Lead Form Number:**

| Review Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---|---|---|---|---|---|---|---|
| Approved-Closed | MISTM100-AR (07/09) | Policy/Contract/Fraternal Certificate | Individual Policy, Short Term Medical Insurance | Revised | Replaced Form #: MISTM100-AR<br>Previous Filing #: MRKC-125633664 | 36 | MISTM100-AR 07-09.pdf |

# MARKEL INSURANCE COMPANY
# Deerfield, IL

## INDIVIDUAL POLICY
## SHORT TERM MEDICAL INSURANCE

Policy Number: [12345]
Policy Date: [Month, Day, Year]

Policyholder: John Smith

The Policy will be administered on Our behalf by the "Administrator:" [ABC Administrator]

This Policy is delivered in Arkansas and shall be governed by the laws thereof.

The consideration for this Policy is Your Application and the payment of premiums as provided in the Policy. This Policy and Your attached Application constitute the entire contract. Only an executive officer of Markel Insurance Company can authorize a change of the Policy or Benefits.

**10 DAY RIGHT TO RETURN THE POLICY**

If for any reason You are not satisfied with this Policy, You may return it to Markel within 10 days after You receive it. We will refund any premium paid and the Policy will be deemed void, just as though it had not been issued.

**THIS IS NON-RENEWABLE SHORT-TERM INSURANCE AND MAY NOT BE RENEWED AT THE END OF THE COVERAGE PERIOD. PLEASE READ ALL DOCUMENTS CAREFULLY.**

**Policyholder Service Office of Company:** [SASid Insurance Development]
**Address:** [462 Midland Road, Janesville, WI, 53546]
**Telephone**: [1-800-279-2290]
**Claims Service Office of Company:** [International Funding, Ltd.]
**Address:** [1 South Pinckney Street, Suite 800, Madison, WI 53703]
**Telephone:** [1-800-610-1920]

If we at Markel Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

**Arkansas Insurance Department**
**Consumer Services Division**
**1200 West Third Street**
**Little Rock, AR 72201-1904**
**Telephone: (501) 371-2640 or 1-800-852-5494**

**Markel Insurance Company**

President

Secretary

# INDEX

## SCHEDULE OF BENEFITS

**Coverage is provided under Policy Number: [12345] [ABC PLAN #]**

**Issued to Policyholder: [John Smith]**

Coverage Period: [30 – 185 days] or [365 days]
Effective Date:
Expiration Date:

The premium payable for this insurance is on file with the Administrator and Markel Insurance Company.

Premium Payment Intervals available to Insured Persons: [Monthly/Quarterly/Semi-Annually/Annually]

Premium Due Date: The Effective Date and the first day of each succeeding interval.

Hospital admissions and lengths of stay are subject to pre-certification by a Professional Review Association as stated below:

### PRE-ADMISSION CERTIFICATION NOTICE:

This Policy requires a Pre-Admission Certification by a "Professional Review Organization" prior to Inpatient hospitalization or surgery of an Insured Person as follows:

(a) Ten days prior to a non-emergency hospitalization; surgical procedure; or
(b) Within 48 hours or on the first business day following an Emergency admission; or
(c) Within 48 hours of delivery for complicated childbirth.

The Professional Review Organization shall review the applicable information and determine the following:

(a) Medical necessity of the Inpatient hospitalization and/or surgical procedure to be performed;
(b) The appropriate length of stay; and
(c) Any appropriate extension(s) of the length of stay beyond that which was initially certified.

The Professional Review Organization's purpose is to determine medical necessity only. A determination of medical necessity does not guarantee or imply benefits at any time. All Inpatient hospitalizations and/or surgical procedures are subject to the Limitations and Exclusions of the Policy.

Non-compliance with the Pre-Admission Certification procedure will result in a reduction in benefits to the lesser of: $1,000; or 50% of the Eligible Expense. This penalty will be taken no more frequently than once per Inpatient hospitalization or surgery, unless the Insured Person is incapacitated and unable to contact Us. In such cases, a representative of the Insured Person, their legal agent, or the provider of service must contact Us as soon as possible.

Information and procedures necessary for Pre-Admission Certification have been issued to each Insured Person. An Insured Person may obtain more information regarding Pre-Certification and its procedures from the Administrator.

The Deductible Amount, Coinsurance Percentage Payable, Coinsurance Limit, and Overall Maximum Benefit Payable amount(s) are applicable to each Insured Person and for all benefits unless specifically noted elsewhere in the Policy.

**[DEDUCTIBLE AMOUNT PER COVERAGE PERIOD:**

| | |
|---|---|
| For all Eligible Expenses, with the exception of Mammograms and Pap Smears: | [$250 - $5000] per person, per Coverage Period. |
| Mammograms and Pap Smears: | Not subject to the Deductible, only Coinsurance Percentage Payable is applicable.] |

[OR]

**DEDUCTIBLE AMOUNT PER CAUSE:**

| | |
|---|---|
| For all Eligible Expenses with the exception of Mammograms and Pap Smears: | [$250 - $1000] per person, per cause, as elected. |
| Mammograms and Pap Smears: | Not subject to the Deductible |

If You elect the Per Cause Deductible, You must satisfy Your elected Deductible Amount for each incident or subsequent incidents for the same Injury or Sickness before any other Eligible Expenses will be paid for such incident.]

| | |
|---|---|
| **COINSURANCE LIMIT: (Out of Pocket Limit)** | $10,000 per person, per Coverage Period, subject to the Overall Maximum Benefit Payable. |

**COINSURANCE PERCENTAGE PAYABLE: (After satisfaction of the Deductible Amount)**

| | |
|---|---|
| For all conditions, unless specifically noted elsewhere in the Policy: | [50% - 100%] of Eligible Expenses up to the Coinsurance Limit.<br>Thereafter, [80% - 100%].<br>All Eligible Expenses are subject to Usual and Customary Charges and the Overall Maximum Benefit Payable. |

| **HOSPITAL INPATIENT DAILY ROOM RATE:** | **MAXIMUM BENEFIT PAYABLE:** |
|---|---|
| A. For normal care: | The Average Semi-Private Room Rate |
| B. For Intensive Care: | [1 – 3] times the Average Semi-Private Room Rate |
| **SURGEON:** | Professional Fees Payable |
| **ASSISTANT SURGEON/CO-SURGEON:** | Up to 20% of the lead surgeon's allowable benefit. |
| **SURGEON'S ASSISTANT**: | Up to 15% of the lead surgeon's allowable benefit. |

| | |
|---|---|
| **ANESTHESIOLOGIST:** | Up to 20% of the lead surgeon's allowable benefit. |
| **PRIVATE DUTY NURSING**: | |
| Maximum Rate: | $75 per 8 hour shift |
| Maximum Payment Period: | 90 shifts per Coverage Period |
| **SKILLED NURSING FACILITY**: | |
| Maximum Daily Room Rate: | $30 per day |
| Maximum Payment Period | 30 days per Coverage Period |
| **GROUND AND AIR AMBULANCE SERVICES**: | |
| Maximum Benefit: | $250 per trip. |
| **ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) and HUMAN IMMUNE DEFICIENCY VIRUS (HIV) related illness:** | |
| Maximum Benefit: | $10,000 per person per Coverage Period |
| **HUMAN ORGAN and TISSUE TRANSPLANTS:** | |
| Maximum Benefit: | $125,000 per person per Coverage Period |
| **SPINAL MANIPULATION or ADJUSTMENT:** | |
| Maximum Benefit: | $1,000 per person per Coverage Period |
| **OUTPATIENT PHYSICAL THERAPY SERVICES:** | |
| Maximum Benefit: | 12 visits per person per Coverage Period |
| **HOME HEALTHCARE VISITS and SERVICES:** | |
| Maximum Benefit: | 40 visits per person per Coverage Period<br>$40 per 8 hour shift |
| **HOSPICE CARE and SERVICES:** | $5,000 per person per Coverage Period |
| **COLORECTAL CANCER SCREENING:** | $300 per person per Coverage Period |
| **DENTAL ANESTHETIC SERVICES:** | $250 per person per Coverage Period |
| **OVERALL MAXIMUM BENEFIT PAYABLE (includes all conditions, all benefits):** | $1,000,000 per person per lifetime. |

## ELIGIBILITY AND EFFECTIVE DATES

### ELIGIBILITY - WHO IS ELIGIBLE

**EE-10 YOU**

You will be eligible for insurance on Yourself as long as:

(1) You are at least 2 years of age but less than 65 years of age.
(2) You are not covered as a Dependent under another group policy.
(3) You are not pregnant or are an expectant father at the time of application.
(4) You are required to have a social security number.
(5) You are not a member of the armed forces.
(6) You submit a written application for insurance; provide Evidence of Insurability, if evidence is required; and meet Our Enrollment and Underwriting Requirements.
(7) You pay all required premiums when due.

**EE-20 YOUR SPOUSE AND DEPENDENT CHILDREN**

You will be eligible to apply for insurance for Your Spouse and Dependent Children who:

(1) Meet the definitions of Spouse and Dependent Children.
(2) Are not pregnant at the time of application.
(3) Are not members of the armed forces.
(4) For whom a written application for insurance and Evidence of Insurability, if required by Us, has been approved, and each meets Our Enrollment and Underwriting Requirements.

If You and Your Spouse are both covered as Insured Persons, only one parent will be eligible for insurance on any Dependent Children You may have.

**EE-30 ENROLLMENT REQUIREMENTS**

You and Your Spouse and Dependent Children who desire coverage must complete and submit an application and provide any other documents (including Evidence of Insurability) as deemed necessary by Us. You must submit the required premium with Your application form. Any misrepresentation or omission of information in Your application or any documents submitted to Us may result in rescission of all coverage for all Insured Persons.

**EE-40 UNDERWRITING REQUIREMENTS**

All Insured Persons are subject to Our underwriting requirements. We reserve the right to accept or decline any applicant at Our discretion. Our underwriting requirements will be as determined by Us.

**EE-50 ADDITIONAL CONDITIONS**

Insurance on any Insured Person will not be effective unless all Eligibility Requirements are met and You receive written acceptance from Us. Insurance on an Insured Person will not be effective unless premium is paid and accepted by Us for such insurance. You will be insured for coverage on Your dependents only if You are an eligible Insured Person. Issuance of a Policy is not a waiver of any of the above conditions.

## EFFECTIVE DATES

**ED-10 YOU**

Coverage is effective on You, and Your Spouse and Dependent Children who were included in Your initial application form, as of the Effective Date shown in Your Schedule of Benefits, provided that You meet Our Eligibility, Underwriting and Enrollment requirements. Coverage will not become effective for any applicant whose medical history changes prior to coverage

approval, such that the applicant's answer would be "Yes" to any of the medical history questions in the application if such applicant is the Insured Person, coverage is automatically declined for all persons included in the application.

**ED-20 ADDITIONS**

You may desire to apply for coverage for a previously uncovered Spouse or Dependent Child. To do so, the following requirements must be met:

(1) You must complete and submit to Us for approval, an application form for such Spouse or Dependent Child.
(2) Such person must meet Our Eligibility, Underwriting and Enrollment Requirements.
(3) You must pay any additional premium, if approved for coverage.

**ED-30 EXCEPTIONS**

**Newborn Dependent Children**

Coverage for newborn Dependent Children will become effective at birth and remain in force only for 90 days. For coverage to continue, We must be notified of the birth of such newly born Dependent Child in writing within 90 days after the date of birth. If such notice is not received within the 90-day period, a later application will be subject to Our Underwriting Requirements. If approved, coverage for the newborn will not be effective until the first of the month following such approval by Us.

**Children Pending Adoption:**

Coverage for a child for whom a petition for adoption has been filed, will become effective from the date the petition is filed, if coverage is applied for within 60 days of such filing. Coverage for an adopted newborn child is from the moment of birth, if applied for within 60 days after birth. Coverage ceased upon the dismissal or denial of a petition for adoption.

**ED-40 WHEN CHANGES IN COVERAGE OCCUR:**

Any change in benefits which occurs automatically under the Policy provisions or Schedule of Benefits will become effective on the date that the status of the Insured Person changed.

Any request for an increase or decrease in either benefits or coverage is subject to the approval of Our Administrator or Us. Should changes in coverage be requested, such changes shall not become effective until the first premium due date following the date of the Administrator's or Our written approval.

If any requested change increases benefits or coverage, the effective date of the increase will be delayed for an Insured Person who is confined for medical treatment in an institution. The delay will end and the increase shall become effective on the day following his final medical discharge from such Confinement.

## TERMINATION OF INSURANCE

**T-10 TERMINATION OF AN INSURED PERSON'S INSURANCE:**

Your insurance will automatically terminate on the earliest of the following dates:

(1) The date that Your Policy terminates.
(2) The due date of a premium payment that is not paid when due, if such payment has not been made within 31 days following such premium due date.
(3) The date that We determine fraud or material misrepresentation has been made by You or with Your knowledge in filing a claim for benefits under the Policy.
(4) The date that You enter full-time active duty in the armed forces of any country or international organization.
(5) The date You become eligible for Medicare.

(6) The earlier of: (1) the date Your elected Coverage Period expires; or (2) [3,6,12 months] from Your Effective Date of insurance, whichever occurs first.

**T-20 TERMINATION OF AN INSURED DEPENDENT'S INSURANCE:**

An insured Dependent's insurance will automatically terminate on the earliest of the following dates:

(1) The date that his Policy terminates.
(2) The due date of a premium payment that is not paid when due, if such premium payment has not been made within 31 days following such premium due date.
(3) The date that the Dependent's insurance under the Policy is discontinued.
(4) The date that We determine fraud or material misrepresentation has been made by the Insured Person or insured Dependent or with the Insured Person's or insured Dependent's knowledge in filing a claim for benefits under the Policy.
(5) The date that the Insured Person's insurance terminates, except if termination is due to the Insured Person's death, an insured Dependent Spouse may elect to continue coverage for insured Dependents for the duration of the Coverage Period by making written request for such coverage and by continuing payments toward the cost of that insurance. When such an election is made, the Spouse will be considered the Insured Person under the terms of the Policy.
(6) The date the Insured Person or insured Dependent becomes eligible for Medicare.
(7) The date that he ceases to be an eligible Dependent, except that, if upon attaining any limiting age, a Dependent Child is mentally or physically incapable of earning his own living and is chiefly dependent upon the Insured Person for support and maintenance, benefits with respect to said Dependent may be continued on a premium paying basis during the continuance of such incapacity, provided that: (a) proof, in writing, of such incapacity has been given to Us when the Dependent child attains the limiting age or (b) We shall have the right during continuance of insurance to require due proof of the continuance of the incapacity and to have the Dependent child examined by Physicians designated by Us. The continuance of insurance as described herein, shall cease in the event: (1) of the termination of the Policy; or (2) of the termination of the Insured Person's insurance; or (3) of the discontinuance of Dependent's insurance under the Policy.
(8) The earlier of: (1) the date the Insured Person's elected Coverage Period has expired; or (2) [3] [6] [12] months from the Effective Date of the Insured Person's insurance, whichever occurs first.

## PREMIUMS

**P-10** The premiums applicable with respect to individual persons insured under the Policy are on file with the Administrator and Us. Any references to age shall refer to the person's attained age on any premium due date. The first premium due date shall be the Policy Effective Date. Subsequent premiums are due as noted in the Policy. All premiums paid to Our Administrator or Us will be fully earned at the time of payment and no premium will be refunded unless the Insured Person elects to terminate their coverage within ten days of issuance/receipt of their Policy.

**P-20** We reserve the right to change the rates on any premium due date on or after the first Policy Anniversary Date. 30-days advance written notice of any such change must be given to the Insured Person.

## SHORT TERM MEDICAL INSURANCE

**M-10 WHAT IS COVERED:**

If an Insured Person incurs Expenses for medical diagnosis, treatment, supplies or services, as a result of Injury or Sickness which occurs while his insurance under the Policy is in effect, We will pay the Coinsurance Percentage Payable, shown in the Schedule of Benefits, of all Eligible Expenses incurred during a Coverage Period in excess of the Deductible Amount, subject to the Limitations and Exclusions of the Policy and the Overall Maximum Benefit Payable.

**M-20 ELIGIBLE EXPENSES:**

Eligible Expenses are subject to a determination of Medically Necessary, Usual and Customary Charges, and Pre-Admission Certification, provided that they are not limited or excluded under Limitations and Exclusions. Eligible Expenses include the following:

(1) **HOSPITAL CHARGES** -

(a) Room and board for Confinement in a Semi-Private Room, up to the Hospital's average Semi-Private Room Rate;

(b) Room and board for Confinement in an Intensive Care Unit, Cardiac Unit, or other similar licensed Inpatient unit except unless specifically noted;

(c) Medical services performed and supplies used during Confinement; and

(d) Outpatient services performed and supplies used with the exception of individual professional fees.

(2) **AMBULATORY SURGICAL CENTER CHARGES** – Treatment in an Ambulatory Surgical Center for medical care, but only if the charges are made for a condition that would normally require Hospital care.

(3) **SKILLED NURSING FACILITY CONFINEMENT CHARGES** – Treatment in a Skilled Nursing Facility for room and board while the Insured Person is continuously Confined as a Registered Bed-Patient. The Confinement must start within 14 days after the end of a Medically Necessary Hospital Confinement of at least three consecutive days. The Confinement must be ordered by a Physician to convalesce from the Sickness or Injury that caused the prior Hospital Confinement. If, within 14 days after the end of a Skilled Nursing Facility Confinement, the Insured Person is again Confined for the same cause as for the prior Confinement, both Confinements will be deemed to be continuous and eligible for consideration of benefits.

(4) **PHYSICIAN, SURGEON, and ANESTHESIOLOGIST CHARGES** – Treatment by a duly licensed Physician for diagnosis, treatment, and surgery.

(5) **NURSING CHARGES** – Treatment by a registered graduate Nurse (R.N.) or licensed practical Nurse (L.P.N.). The charges must be for nursing care.

(6) **PHYSICAL MEDICINE CHARGES** – Treatment for rehabilitative services, including but not limited to those for occupational, physical, rehabilitative, and speech therapies. Also included is Medically Necessary preventative physical therapy for multiple sclerosis. These services must include a prescriptive care plan from a treating or referring Physician and be performed by a duly licensed Physician, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Licensed Speech Therapist (L.S.T.), or Licensed Physical Therapist (L.P.T).

(7) **HOME HEALTH AGENCY CHARGES** – Treatment by a Home Health Agency for the following treatments, services and supplies when they are furnished to a person in accordance with a Home Health Care Plan. The Plan must be implemented within 14 days

after the end of a Medically Necessary Hospital Confinement, as a Registered Bed-Patient, of at least five consecutive days:

(a) Part-time or intermittent services of a Home Health Aide;

(b) Part-time or intermittent nursing care furnished, or supervised by a registered graduate Nurse (R.N.); but only if the charge is not also claimed as an Eligible Expense under (5) above;

(c) Physical, occupational or speech therapy; but only if the charge is not also claimed as an Eligible Expense under (6) above.

(d) Laboratory services by, or on behalf of, a Home Health Agency and medical supplies and Prescription Drugs which can be lawfully dispensed only by a licensed pharmacy at a Physician's written prescription; to the same extent that benefits for these services, supplies and Prescription Drugs would have been available to the Insured Person if he were then Confined as a Registered Bed Patient in a Hospital or convalescent nursing home.

Each visit by an employee of a Home Health Care Agency will count as one visit. Each four hours of service by a Home Health Aide will count as one visit. Not included are charges for: (a) domestic or housekeeping services unrelated to patient care; (b) home food services; (c) Mental/Nervous Disorder; (d) rental or purchase of renal dialysis equipment or supplies; or (e) nursing home or Skilled Nursing Facility care. The Insured Person must be under the continuing care of a Physician during the period of his Home Health Care Plan.

(8) **HOSPICE CARE AND SERVICES** – Treatment and services provided by a licensed Hospice provider to a terminally ill Insured Person with a life expectancy of six months or less. Eligible Expenses will include, but are not limited to the following:

(a) Part-time or intermittent home nursing care by or under the direction of a licensed Nurse;

(b) Physical, respiratory, or speech therapy performed by a licensed therapist;

(c) Counseling by a licensed social worker or pastoral counselor for the Insured Person, a member of the Insured Person's immediate family, the primary care giver, and individuals with significant personal ties to the Insured Person who is terminally ill.

Hospice services must be:

(a) Under active management through an agency licensed or certified to provide hospice services and which is responsible for coordinating all such services; and

(b) Provided only when the Physician has submitted written certification to Us that the Insured Person is terminally ill with a life expectancy of six months or less. Periodic reviews of medical necessity may be necessary.

This benefit does not include the services of volunteers or persons who do not regularly charge for their services.

(9) **SPINAL MANIPULATION OR ADJUSTMENT** - Treatment by a Physician or Licensed Doctor of Chiropractic for physical manipulation involving the spine; traction; inversion therapy; hot or cold packs; electrical stimulation therapy; diathermy; therapeutic exercise; neuromuscular reeducation; gait training; thermography; biofeedback therapy; hydrocollar therapy; passive motion therapy; and office visits, consultations; x-rays, laboratory and other diagnostic studies performed in connection with spinal manipulations and spinal adjustments, or spinal therapy. Charges for massage therapy are considered only when performed by a Licensed Physical Therapist or Physician in conjunction with treatment intended to rehabilitate Injury or Sickness related to loss of limb(s), damage to peripheral nerves, spinal cord, musculoskeletal system, or other soft-tissue Injury.

(10) **MAMMOGRAPHY/PAP SMEAR** – Coverage is provided for the Expense for screening by low-dose mammography for the presence of occult breast cancer for all women age 35 and older, inclusive of the following:

(a) A baseline mammogram for women 35 to 40 years of age;
(b) An annual mammogram for women 40 years of age or older; and
(c) A mammogram at intervals considered Medically Necessary by the woman's health care provider for women having a history of breast cancer or other risk factors.
(d) One routine cervical cytologic screening for women.

Such charges will be exempt from any Deductible Amount applicable under the Policy.

(11) **BONE MASS MEASUREMENT AND OSTEOPOROSIS** – Coverage is provided for bone mass measurement and for the diagnosis and treatment of osteoporosis.

(12) **HUMAN ORGAN AND TISSUE TRANSPLANTS** - Hospital, Physician and medical supply charges for non-Experimental human organ and/or tissue transplants or replacements.

(13) **SERVICES AND SUPPLIES:**
(a) X-ray exams and microscopic and laboratory tests and analyses.
(b) Anesthesia, oxygen and their administration.
(c) Diagnostic imaging, radioactive isotope therapies, and other therapeutic services using x-ray or radiation.
(d) Blood or blood derivatives and their administration.
(e) Casts, splints, trusses, braces or crutches but not their replacement or repair; surgical dressing or artificial limbs or eyes excluding repair or replacement of lost items.
(f) Prescription or legend drugs which are administered during a Hospital Confinement and dispensed only by a licensed pharmacy and which a Physician prescribes in writing to treat a specific Injury or Sickness. Off-Label drugs not approved by the US Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved are covered provided: (i) the drug has been recognized as safe and effective for treatment of that specific type of cancer in the American Hospital Formulary Service drug information or the United States Pharmacopoeia dispensing information; (ii) the drug has been recognized as safe and effective for treatment of that specific type of cancer in two articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature.
(g) Rental of an iron lung or other mechanical equipment to treat respiratory paralysis; rental of a wheelchair or Hospital bed; or equipment to administer oxygen; not to exceed purchase price.
(h) Transportation of the Insured Person needing treatment by a professional ground or air ambulance to a local Hospital, only if the condition so requires**.**

(14) **CHILD PREVENTIVE HEALTH CARE SERVICES** - Benefits are covered for periodic preventive care visits from the moment of birth until the age of 18. Such services rendered during a periodic review will only be covered to the extent that those services are provided by or under the supervision of a single Physician during the course of one visit.

Benefits shall be limited to one visit payable to one provider for all of the services provided at each visit cited in this section. Physical exams that are required by third parties are not covered. All charges are subject to the Deductible Amount. Benefits for vaccines and immunizations are exempt from any Deductible Amount, Coinsurance Percentage or dollar limits.

"Children's Preventive Health Care Services" means physician-delivered or physician-supervised services from birth to age 18, with 20 Periodic Preventive Care Visits, including medical history, physical examination, development assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards.

"Periodic Preventive Care Visits" means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practices.

(15) **COLORECTAL SCREENING** –Benefits are covered for colorectal screenings for:

(a) Individuals over 50 years of age or who face a high risk for colorectal cancer because of: (i) The presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy; (ii) A family history of colorectal cancer in close relatives of parents, brothers, sisters, or children; (iii) Genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis; (iv) A personal history of colorectal cancer, ulcerative colitis, or Crohn's disease; or (v) The presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and

(b) Any additional or expanded definition of "persons at high risk of colorectal cancer" as recognized by medical science and determined by the Director of the Division of Health of the Department of Health and Human Services in consultation with the University of Arkansas for Medical Sciences.

(16) **DIABETES** – Benefits are covered for treatments, including, but not limited to, equipment, supplies used in the monitoring of blood glucose and insulin administration and Diabetes Self-management Training.

"Diabetes self-management training" means instructions in an inpatient or outpatient health setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding programs the primary purposes of which are weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

(17) **IN VITRO FERTILIZATION** – Benefits are covered for services performed at a medical facility, licensed or certified by the Department of Health, those performed at a facility certified by the department that conforms to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics, or those performed at a facility certified by the department that meets the American Fertility Society minimal standards for programs of in vitro fertilization.

(18) **LOSS OR IMPAIRMENT OF SPEECH OR HEARING** - Benefits are covered for the necessary care and treatment of loss or impairment of speech or hearing, subject to the same deductible, coinsurance and limits as other covered services in the Policy.

"Loss or impairment of speech or hearing" shall include those communicative disorders generally treaty by a licensed speech pathologist or audiologist.

(19) **MUSCULOSKELETAL DISORDERS OF FACE, NECK OR HEAD** – Benefits are covered for Medically Necessary diagnosis and medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head including temporomandibular joint disorder and craniomandibular disorder.

(20) **PKU/MEDICAL FOODS & LOW PROTEIN MODIFIED FOOD PRODUCTS** – Benefits are covered for low protein modified food product and medical food for the treatment of inherited metabolic disease.

"Low protein modified food product" means a food product that is specifically formulated to have less than one gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease."

"Medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician."

(21) **PROSTATE CANCER SCREENING** – Coverage is provided for the Expense for screening performed by a qualified medical professional for the early detection of prostate cancer in men 40 years of age and older, according to the National Comprehensive Cancer Network guidelines, as in effect on January 1, 2009, as well as a prostate specific antigen blood test recommended by a medical practitioner. Such charges will be exempt from any Deductible Amount applicable under the Policy.

**EXPENSES INCURRED**: An Eligible Expense will be considered to be incurred at the time the service or the supply to which it relates to is provided.

**M-30 ALLOCATION AND APPORTIONMENT OF BENEFITS:**

We reserve the right to allocate the Deductible Amount to any Eligible Expenses and to apportion the payment of benefits between the Insured Person and any Insured Dependent designated by the Insured Person. Such allocation and apportionment shall be conclusive and shall be binding upon the Insured Person and all assignees.

**M-40 EXTENSION OF COVERAGE:**

An extension of coverage will be provided if an Insured Person is Totally Disabled and receiving benefits for a Hospital Confinement on the date that the Policy terminates or his coverage under the Policy terminates for reasons other than nonpayment of premium, fraud or material misrepresentation.

Benefits will be payable only for Eligible Expenses incurred in connection with the same Injury or Sickness causing the Total Disability at the time of termination. Timely payment of premium is required to continue coverage.

The extension of coverage will end on the earlier of:

(1) The date the Hospital Confinement for the Total Disability ends;
(2) The end of the 90 day period following his termination date;
(3) The date premium payment is not paid when due; or
(4) The date the Overall Maximum Benefit Payable has been paid. Benefits payable during this extension of coverage are subject to a new Deductible Amount and satisfaction of the Coinsurance Limit.
(5) The earliest date permissible by law.

## LIMITATIONS AND EXCLUSIONS

**LE-10 LIMITATIONS:** Eligible Expenses are limited by the following

(1) Hospital Inpatient Daily Room Rate Maximum - Eligible Expenses do not include charges by a Hospital for room and board and general or floor nursing care unless they are incurred while the Insured Person is a Registered Bed-Patient. Also, they do not include any portion of such a charge in excess of the Maximum Daily Room Rate shown in the Schedule of Benefits for normal care.

(2) Hospital Inpatient Intensive Care Unit Maximum - Eligible Expenses do not include any portion of the charge made by a Hospital for care and treatment received in an Intensive Care Unit that is in excess of the Intensive Care Unit Maximum shown in the Schedule of Benefits.

(3) Private Duty Nursing Maximum - Eligible Expenses do not include charges for private duty nursing service by a registered graduate Nurse (R.N.) in excess of the Maximum Private Duty Nursing Rate and Payment Period shown in the Schedule of Benefits.

(4) Skilled Nursing Facility Maximum - Eligible Expenses do not include any portion of the charge by a Skilled Nursing Facility for room and board and general or floor nursing care in excess of the Skilled Nursing Facility Maximum Daily Room Rate shown in the Schedule of Benefits and do not include any such charges for more than the Maximum Payment Period of Skilled Nursing Facility Confinement shown in the Schedule of Benefits.

(5) Ground and Air Ambulance Services Maximum - Eligible Expenses do not include charges for ambulance transportation to a local Hospital that are in excess of the Ambulance Service Maximum shown in the Schedule of Benefits.

(6) AIDS/HIV Maximum - Eligible Expenses do not include charges in excess of the Acquired Immune Deficiency Syndrome/Human Immunodeficiency Virus Maximum shown in the Schedule of Benefits.

(7) Human Organ and Tissue Transplants Maximum - Eligible Expenses do not include charges in excess of the Human Organ and Tissue Transplant Maximum shown in the Schedule of Benefits.

(8) Spinal Manipulation or Adjustment - Eligible Expenses do not include charges in excess of the Spinal Manipulation or Adjustment Maximum shown in the Schedule of Benefits.

(9) Eye Examinations, Eyeglasses, Hearing Aids and Surgery – Eligible Expenses do not include charges incurred in connection with routine eye examinations, eyeglasses, determination of refractive states, correction or treatment of eye refractions, the purchase, fitting or adjustment of contact lenses or glasses, or treatment of cataracts, routine hearing exams to access need for or change in hearing aids, hearing aids or their fittings, Lasik, RK or other corrective vision surgery, hearing loss surgery; unless the charges are necessarily incurred to treat, within 90 days of its occurrence, an accidental bodily Injury sustained while the Insured Person was insured for this benefit and the treatment giving rise to the charges begins within 90 days after the date of the Accident causing the Injury.

(10) Dental Anesthetic Services - Eligible expenses will include those for Insured Person's in a Hospital or an Ambulatory Surgical Center if any of the following applies: (1) the Insured Person is a child age 7 or under who is determined by two licensed dentists to require immediate dental treatment in a Hospital or ambulatory surgical center; (2) the Insured Person a serious mental or physical condition; or (3) the Insured has a significant behavioral problem determined by the Insured Person's Physician.

(11) Assistant Surgeon/Co-Surgeon, Surgeon's Assistant, Anesthesiologist – Eligible Expenses do not include charges in excess of the Assistant Surgeon/Co-Surgeon, Surgeon's Assistant, Anesthesiologist Maximum shown in the Schedule of Benefits.

(12) Hospice Care and Services - Eligible Expenses do not include charges in excess of the Hospice Care and Services Maximum shown in the Schedule of Benefits.

(13) Home Health Care Visits and Services – Eligible Expenses do not include charges in excess of the Home Health Care Visits and Services Maximum shown in the Schedule of Benefits.

(14) Outpatient Physical Therapy Services - Eligible Expenses do not include charges in excess of the Outpatient Physical Therapy Services Maximum shown in the Schedule of Benefits.

**LE-20 EXCLUSIONS:** We will not pay benefits, and charges will not accrue toward any Deductible Amount, for Expenses incurred as a result, directly or indirectly, of any of the following:

(1) [Pre-Existing Conditions, as defined.

(2) Expenses that the Insured Person is not required to pay, or those charges that would not have been billed if no insurance existed.

(3) Charges for custodial maintenance; pre-marital screenings or exams; routine services for general physical examinations; physical examinations that are required by third parties; diagnostics, screenings and research; preventative or prophylactic care; and immunizations, unless specifically noted in the Policy.

(4) Medical Expenses that are eligible for payment under an automobile medical payment benefit, regardless of fault.

(5) Injury or Sickness resulting from war, either declared or undeclared; riot or any act incidental to war or riot; while committing or attempting to commit felony; intentionally self-inflicted Injuries; suicide or attempted suicide, while sane or insane.

(6) Injury or Sickness incurred during military service or while on active duty. Upon written notice to Us of entry into active duty, any unused premium will be returned to the Insured Person on a pro-rated basis.

(7) Substance Abuse Treatment unless specifically provided by State Mandated benefits.

(8) Charges incurred by an insured Dependent who is a newborn child not yet discharged from the Hospital, unless the charges are necessarily incurred as the result of, and to treat, premature birth, congenital Injury or Sickness, or Injury or Sickness sustained during or after birth.

(9) Charges related to elective cesarean section when no complication is present or voluntary termination of a normal Pregnancy including, but not limited to, the cost of any drug, contraceptive, supply, treatment, or procedure intended to prevent conception or childbirth.

(10) Any work-related accidental bodily Injury or Sickness.

(11) Routine charges for the care and/or treatment of a normal Pregnancy or childbirth with the exception of those Expenses related to a Complication of Pregnancy as defined in the Policy.

(12) Any services, supplies or treatment furnished by the Insured Person, an Insured Person's Immediate Family, or Employer.

(13) Services or supplies rendered to a transplant donor of any organ or bodily element or the acquisition cost of any organ or bodily element.

(14) Services related to or for the purpose of treating infertility or causing Pregnancy, including but not limited to, diagnostic testing; drugs; medicines; artificial insemination; in vitro fertilization; and embryo transplants; or any condition or complication caused by or resulting from such treatment.

(15) Participation in high-risk sports, activities, or occupations such as: skydiving; scuba diving; bungee jumping; hang gliding; or ultra light gliding; traveling in or on any all terrain vehicles such as, but not limited to: dirt bikes, all terrain vehicles, snowmobiles, or go-carts; racing with any motorcycle, boat or any form of aircraft; participation in any sports for pay or profit; participation in inter-collegiate sports; and any rodeo events.

(16) Charges that do not meet the definition or are not specifically identified under the Policy as Eligible Expenses, including amounts in excess of the Usual and Customary charges for the geographic area in which the charges are incurred.

(17) Charges determined to be for educational purposes or charges that may be provided through an educational program or facility.

(18) Voluntary inhalation or ingestion of any gas, poison or poisonous substance.

(19) Cosmetic, reconstructive or plastic surgery unless:
(a) As a result of an Injury that occurred while the Insured Person was insured under the Policy; or
(b) To correct the disorder of a normal bodily function if the disorder had its inception while the Insured Person was insured under the Policy; or
(c) Expenses are incurred for reconstructive breast surgery following a mastectomy due to illness occurring within the terms of the Policy. Reconstructive surgery includes reconstruction of the other breast to produce a symmetrical appearance if the patient elects, prostheses and physical complications in all stages of mastectomy including lymph edemas.

(20) Obesity, including any treatment, advice, consultation, medication, program or surgery recommended for reducing weight whether or not such weight reduction is recommended for reasons other than, or in addition, to, obesity; or any complication resulting from the treatment or surgery for weight reduction.

(21) Care or treatment of: weak, strained or flat feet; instability or imbalance of the foot; metatarsalgia; bunions; corns; calluses; or toenails; except for charges: (i) by a Hospital during Confinement; or (ii) for the care and treatment of a metabolic or peripheral vascular disease; or (iii) for immediate repair of Injury from an Accident that occurred while the Insured Person was insured under the Policy.

(22) Treatment related to: gender change or modification; sterilization or elective reversal of surgical procedures; breast reduction unless Medically Necessary; breast enlargement for

any reason; or the treatment or testing for sexual dysfunction or inadequacies whether such condition has a physical or organic basis or origin.

(23) Services or supplies of a common household use, including but not limited to: exercise cycles; air or water purifiers; air conditioners; allergenic mattresses; and blood pressure kits.

(24) Charges for items or services of convenience, including but not limited to: admission kits; telephone; slippers; or homemaker services; supportive service focusing on activities of daily life such as bathing; dressing; feeding; or skin and/or bladder care; administration of oral medication or eye drops, except as specifically covered in the Policy.

(25) Experimental or investigational service, supplies, or treatments.

(26) Travel or travel expense, even though prescribed by a Physician.

(27) Outpatient Prescription Drugs; medicines; vitamins (including prenatal vitamins); mineral or food supplements; or any over the counter medicines, whether or not ordered by a Physician.

(28) Charges for the treatment of acne or varicosities of the veins.

(29) Any Expense for the treatment of Injury or Sickness occurring while intoxicated or under the influence of alcohol, illegal drugs, hallucinogenics or narcotics unless said narcotics were prescribed by a Physician and used as recommended. "Intoxicated" and "under the influence" will have the meanings determined by the laws of the jurisdiction of the geographical region in which either the Loss or the cause occurs.

(30) Charges related to transportation, except where specifically covered in the Policy.

(31) Expenses incurred to treat complications resulting from any treatment or care of conditions that are not covered under the Policy.

(32) Expenses related to diagnosing, testing for, or treating a sleeping disorder.

(33) Testing, diagnosis or treatment for or related to learning disabilities; attention deficit disorder; hyperactivity; autism; or related conditions. **]**

**HP-10** **HOSPITAL PRECERTIFICATION**

This Policy requires a Pre-Admission Certification by a "Professional Review Organization" prior to Inpatient hospitalization or surgery of an Insured Person as follows:

(a) Ten days prior to a non-emergency hospitalization; surgical procedure; or
(b) Within 48 hours or on the first business day following an Emergency admission; or
(c) Within 48 hours of delivery for complicated childbirth.

The Professional Review Organization shall review the applicable information and determine the following:

(a) Medical necessity of the Inpatient hospitalization and/or surgical procedure to be performed;

(b) The appropriate length of stay; and
(c) Any appropriate extension(s) of the length of stay beyond that which was initially certified.

The Professional Review Organization's purpose is to determine medical necessity only. A determination of medical necessity does not guarantee or imply benefits at any time. All Inpatient hospitalizations and/or surgical procedures are subject to the Limitations and Exclusions of the Policy.

Non-compliance with the Pre-Admission Certification procedure will result in a reduction in benefits to the lesser of: $1,000; or 50% of the Eligible Expense. This penalty will be taken no more frequently than once per Inpatient hospitalization or surgery, unless the Insured Person is incapacitated and unable to contact Us. In such cases, a representative of the Insured Person, their legal agent, or the provider of service must contact Us as soon as possible.

Information and procedures necessary for Pre-Admission Certification have been issued to each Insured Person. An Insured Person may obtain more information regarding Pre-Certification and its procedures from the Administrator.

REDUCTION OF BENEFITS

To the extent that the otherwise Eligible Expense for the Hospital admission and/or length of stay and/or extensions of stay are not certified by the Professional Review Organization, We will only pay 50% of the benefits under the Policy which would otherwise have been payable for Eligible Expenses, unless the Insured Person is incapacitated and unable to contact Us. In such cases, the Insured Person must contact Us as soon as possible. No benefits will be payable under the Policy in the event such Hospital admission, length of stay or extension of stay is not Medically Necessary.

## CB-10 COORDINATION OF BENEFITS

### I. Applicability

A. This Coordination of Benefits ("COB") provision applies to This Plan when an Insured Person has health care coverage under more than one Plan. "Plan and This Plan" are defined below.

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

(1) Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but

(2) May be reduced when, under the order of benefits determination rules, another Plan determines its benefits first. The above reduction is described in Section IV "Effect on the Benefits of This Plan."

### II. Definitions

A. "Plan" is any of these which provide benefits or services for, or because of, medical or dental care or treatment:

(1) group and non-group contracts, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act (42 U.S.C.A. 301, et seq.), as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

B. "This Plan" is the part of the contract that provides benefits for health care Expenses.

C. "Primary Plan/Secondary Plan:" The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

D. "Allowable Expense" means a necessary, reasonable and customary item of Expense for health care; when the item of Expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

The difference between the cost of a private Hospital room and the cost of a Semi-Private Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

E. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

**III. Order of Benefit Determination Rules**

A. General. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

(1) The other Plan has rules coordinating its benefits with those of This Plan; and

(2) Both those rules and This Plan's rules, in Subsection B below, require that This Plan's benefits be determined before those of the other Plan.

B. Rules. This Plan determines its order of benefits using the first of the following rules which applies:

(1) Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, Member or subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent; except that: if the person is also a Medicare beneficiary, Medicare is

(a) Secondary to the Plan covering the person as a Dependent; and

(b) Primary to the Plan covering the person as other than a Dependent, for example a retired employee.

(2) Dependent Child/Parents not Separated or Divorced. Except as stated in subsection (B)(3) below, when This Plan and another Plan cover the same child as a Dependent of different person, called "parents":

(a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

(b) If both parents have the same birthday, the benefits of the Plan which covered the parents longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in subsection (2)(a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

(3) Dependent Child/Separated or Divorced. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) First, the Plan of the parent with custody of the child;

(b) Then, the Plan of the spouse of the parent with the custody of the child; and

(c) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care Expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Dependent Child/Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care Expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph III subsection B(2) above.

(5) Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule (4) is ignored.

(6) Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:

(a) First, the benefits of a Plan covering the person as an employee, Member or subscriber (or as that person's Dependent);

(b) Second, the benefits under the continuation coverage.

If the other Plan does not contain the order of benefits determination described within this subsection, and if, as a result, the Plans do not agree on the order of benefits, this requirement shall be ignored.

(7) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, Member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

**IV. Effect on the Benefits of this Plan**

A. When This Section Applies. This Section IV applies when, in accordance with Section III "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other plans" in (B) immediately below.

B. Reduction in this Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

(1) The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

**V. Right to Receive and Release Needed Information**

Certain facts are needed to apply these COB rules. We have the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts it needs to pay the claim.

**VI. Facility of Payment**

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

**VII. Right of Recovery**

If the amount of the payments made by Us is more than it should have paid under this COB provision, it may recover the excess from one or more of:

A. The persons it has paid or for whom it has paid;

B. Insurance companies; or

C. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

## CLAIM PROVISIONS AND GENERAL PROVISIONS

### GP-10 CLAIM PROVISIONS:

**Notice of Claim**: When a claim arises, the claimant should notify Us or the Administrator of the Loss in writing. We will furnish a claim form or accept a proof of payment for covered services. This written notice of claim must be given within 20 days after commencement of any Loss covered by the Policy, or as soon as reasonably possible. If the claim form is not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing of Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

**Proof of Loss:** Written proof of Loss must be furnished to Us or to the Administrator. It must be furnished within 90 days of the Loss. Where the Policy provides for payments contingent upon a period of Confinement, these 90 days shall begin at the end of the period for which We are liable. If the claimant does not furnish proof within 90 days as required, benefits shall still be paid for that Loss if: (1) it was not reasonably possible to give proof within those 90 days; and (2) proof is furnished as soon as reasonably possible and, except in the absence of legal capacity, no later than one year after the end of those 90 days.

**When Benefits Are Paid:** We or the Administrator will make payment promptly upon receipt of due written Proof of Loss. Payment shall be made directly to the Insured Person or the provider of the service, as directed by the Insured Person in writing at the time of submitting Proof of Loss. If the Insured Person is deceased or, in Our opinion, is incapable of giving a valid receipt for payment, and if no claim has been made by a duly appointed legal representative, We shall have the option of making payment to either: (1) the Hospital or the person who actually incurred the Loss for which payment is due; or (2) a surviving relative of the Insured Person. Such a payment shall discharge Us from all further liability to the extent of the payment made.

**Appeal of Claim Denial:** If a claim is denied, the Insured Person will receive written notice giving the reason for the denial. If the Insured Person wishes to appeal the denial of the claim, such appeal must be submitted in writing within 60 days from the date of notice. The Insured Person must clearly state the reasons he believes the claim decision is incorrect.

### GP-20 GENERAL PROVISIONS:

**Assignment and Claims of Creditors:** Except as provided below, benefits under the Policy are not assignable unless as otherwise provided by law, benefits payments will be exempt from legal process for debts or liabilities of an Insured Person. You may direct Us to pay benefits to the person or institution on whose charges the claim is based. Any such payment that We make will fully discharge Us to the extent of the payment.

**Calculation and Adjustment of Premiums:** We determine the premium for each Insured Person. We have the right to change premium rates on any premium due date by giving [60 days] advance written notice to You of such change. The premium rates may also be changed at any time the terms of the Policy are changed.

**Changes in Benefits:** Changes in the benefits of an Insured Person will apply only to Eligible Expenses or Losses incurred after the Effective Date of the change.

**Clerical Error:** Clerical errors made by Us in the issuance of Your Schedule of Benefits, Your Policy, or in record keeping for Your Policy will not afford You benefits or validate insurance for which You have not applied and paid the appropriate premium and been approved by Us. We have the right to offset or recover any overpayment of benefits made under the Policy from You.

**Conformity With Statutes:** Any provision of the Policy that is in conflict with the statutes of the jurisdiction in which the Policyholder is located on such date is hereby amended to conform to the minimum requirements of such statutes.

**Contract Changes :** The effective time for any changes made shall be 12:01 A.M. Standard Time at the address of the Policyholder.

**Amendment:** The Policy may be amended or changed at any time or times by written notification to the Policyholder and Us. Insurance provided by the Policy may be amended, changed or canceled without the consent of any Insured Person and without prior notice to him.

**Entire Contract:** The entire contract consists of the Policy, the Certificate, the application of the association, Your application form and any other amendments, endorsements, or documents requested and accepted by Us. No change in the Policy is valid unless approved by Our executive officer. Such approval must be signed by the officer and attached to the Policy. No broker, agent or producer can change or waive any provision of the entire contract or any of Our requirements.

**Grace Period:** You have a 31 day grace period for the payment of each premium due after the first premium. Your coverage will continue in force during the grace period unless You have given Us prior written notice of termination. If the premium is not paid by the end of the grace period, all such insurance will end as of the due date of such premiums, and no Expenses incurred during the grace period will be considered for benefits.

**Incontestability**: All statements made by You will, in the absence of fraud, be deemed representations and not warranties. No such statement will be used in defense of any claim or in a contest under the Policy unless a written copy has been given to You. Any misstatement or omission of information made on Your application form or on any other materials on which We relied to issue, change or increase coverage will be considered a misrepresentation and may be the basis of later rescission of coverage. After coverage for an Insured Person has been in force for two years during the Insured Person's lifetime, We do not have the right to contest that coverage, except for fraud or non-payment of premiums.

**Legal Proceedings:** No proceedings to obtain benefits under the Policy may be brought against Us until the expiration of 60 days after proper written Proof of Loss and any other documentation necessary to establish what benefits are due under the provisions of the Policy have been received by Us. No proceedings may be brought more than three years after proof is required to be filed.

**Misstatement of Age:** If the age of the Insured has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

**Payment of Premiums:** All premiums are paid to Us, or if We direct, to Our authorized representative. Premiums are due monthly, in advance, on the first day of each policy month, or if other than monthly,

the first of the month of the payment period elected by You. Each monthly premium will pay for the insurance then in effect for a period of one month for Insured Persons. Each payment for a period greater than a month will pay for the entire period selected by You. Except as otherwise provided in the Policy, all coverage will terminate on the premium due date if premiums are not paid when due.

**Physical Exam and Autopsy**: We may require, at Our own expense, medical examinations of any person for whom a claim is made or make a request for an autopsy if not prohibited by law.

**Pronouns** – Whenever a personal pronoun in the masculine gender is used, it will be deemed to include the feminine also, unless the context clearly indicates to the contrary.

**Rescission:** A misrepresentation or omission in the application form or other documents provided to Us might be the basis for later rescission of all coverage of all persons insured under the Policy. Rescission voids all coverage as of the Effective Date and means that no benefits will be paid to any person for any claim submitted, whether or not such claim relates to the condition about which information was misrepresented or omitted. We will refund to You premiums paid after deduction for any claims paid out under the Policy by Us.

**Subrogation**: Upon payment of benefits for an Injury or Sickness, We will be subrogated to all rights of recovery an Insured Person may have against any third party responsible for such Sickness or Injury. This includes but is not limited to recoveries against such third party, against any liability coverage for such third party or against an Insured Person's automobile insurance in the event a claim is made under the uninsured or underinsured motorist coverage. Such right extends to all proceeds of any settlement or judgment; but is limited to the amount of benefits We have paid. You must: (1) do nothing to prejudice any right of recovery; (2) execute and deliver any required instruments or papers; and (3) do whatever else is necessary to secure such rights.

If We are precluded by law from exercising Our Subrogation Right, We may exercise Our Right of Reimbursement as defined by the Policy.

**Right of Reimbursement**

If an Insured Person incurs Expenses for Sickness or Injury that occurred due to the negligence of a third party:

(a) We have the right to reimbursement for all benefits We paid from any and all damages collected from the third party for those same Expenses whether by action at law, settlement, or compromise, by the Insured Person, the Insured Person's parents (if the Insured Person is a minor), or Insured Person's legal representative as a result of the Sickness or Injury; and

(b) We are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits we paid for that Sickness or Injury.

We shall have the right to first reimbursement out of all funds the Insured Person, the Insured Person's parents (if the Insured Person is a minor), or the Insured Person's legal representative, is or was able to obtain for the same Expenses We have paid as a result of that Sickness or Injury.

You are required to furnish any information or assistance or provide any documents that We may reasonably require in order to obtain Our rights under this provision. This provision applies whether or not the third party admits liability.

**Unearned Premiums Refund**: Upon the death of an Insured, unearned premiums shall be paid in lump sum within 30 days after the proof of the Insured's death has been furnished to Us.

**Workers' Compensation**: This Policy is not a substitute for Workers' Compensation insurance and does not affect any requirement for Workers' Compensation coverage.

## D-10 DEFINITIONS

**Accident:** means a sudden, unexpected and unintended event, which is identifiable and caused solely by an external physical force resulting in Injury to an Insured Person. Accident does not include a Loss due to disease or Sickness.

**Administrator:** means [ABC Administrator].

**Ambulatory Surgical Center:** means a licensed health care facility whose main purpose is the diagnosis or treatment of patients by surgery. It must: (1) admit and discharge the patient within the same working day; (2) be supervised by a Physician; (3) require a licensed anesthesiologist or licensed certified registered nurse anesthetist to administer anesthesia and remain during the surgery; (4) provide a post-anesthesia recovery room; and (5) have a written agreement with at least one Hospital for immediate acceptance of patients who develop complications.

It does not include: (1) a facility whose main purpose is performing terminations of Pregnancy; (2) an office maintained by a Physician for the practice of medicine; or (3) an office maintained for the practice of dentistry.

**Calendar Year:** means the period of time starting January 1 of a year; it ends on December 31 of the same year.

**Coinsurance Limit (Out of Pocket Limit):** The amount of money that You are required to pay from Your own funds for Eligible Expenses not paid by Us, such as Deductibles and Coinsurance; this does not include Expenses which are not payable by this policy.

**Coinsurance Percentage Payable:** means the applicable percentage specified in the Schedule of Benefits, which We will use in computing the amount payable when benefits are payable under the Policy after satisfaction of any Deductible Amounts.

**Complications Of Pregnancy:** means: (1) conditions requiring Hospital Confinement (when Pregnancy is not terminated) whose diagnoses are distinct from Pregnancy but are adversely affected by Pregnancy or are caused by Pregnancy, such as but not limited to: acute nephritis, nephrosis, cardiac decomposition, missed abortion and similar medical and surgical conditions of comparable severity; and (2) non-elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of Pregnancy which occurs during a period of gestation in which a viable birth is not possible. It does not include false labor, occasional spotting, Physician prescribed rest during the period of Pregnancy, morning sickness, hyperemesis gravidarum, elective cesarean section, pre-eclampsia and similar conditions associated with the management of a difficult Pregnancy not constituting a nosologically distinct complication of pregnancy.

**Confined/Confinement:** means being a Registered Bed patient as an Inpatient in a facility, on the order of a Physician, for Medically Necessary medical treatment for a period of no less than 18 consecutive hours.

**Coverage Period:** means the maximum length of time coverage is in force.

**Deductible Amount:** means that amount specified in the Schedule of Benefits which is the initial out-of-pocket Expense paid by each Insured Person. Such Deductible Amount must first be satisfied by the application of Eligible Expenses which are subject to such Deductible Amount and which are incurred before any other Eligible Expenses will be payable under the Policy.

**Dependent:** means a Spouse or Dependent Child.

**Dependent Child(ren):** means Your unmarried Children, if any, who are primarily dependent upon You for support and maintenance. Each Child must be: (1) less than 19 of age; or (2) at least 19 years of age but less than 25 and be enrolled and attending as a full-time student at an accredited college, university, vocational or technical school. If the Insured Person is supporting a 19 year old Dependent child because of mental retardation or a physical handicap, coverage may be continued. We must receive written notice and proof of such conditions within 31 days of the child's 19th birthday. Thereafter, We may require, at Our expense, such proof once each year. "Children" means natural Children; stepchildren who are residing with You; legally adopted Children; and Children subject to Your legal guardianship.

**Effective Date:** means the date coverage under the Policy, or an insurance or benefit provision as the case may be, goes into force for an Insured Person. It is shown in the Schedule of Benefits.

**Eligible Expenses:** means: (1) treatments, services and supplies which a Physician recommends as Medically Necessary to treat a covered Injury or Sickness; and (2) charges which are Usual and Customary and are incurred by the Insured Person while he is insured under the Policy; and (3) charges which the Insured Person is legally required to pay.

**Emergency:** means a life-threatening medical condition resulting from Injury or Sickness that arises suddenly and requires immediate care to prevent permanent disability or jeopardy to life.

**Evidence Of Insurability:** means proof that a person is acceptable for insurance according to Our current underwriting rules. Such proof is at his expense unless otherwise stated.

**Expense:** means the Usual and Customary charges for Medically Necessary treatment, services and supplies. Such Expense shall not include any amount not customarily charged to persons without insurance.

**Experimental:** means those practices, treatments, drugs, and or therapies not accepted and approved by the American Medical Association, Federal Drug Administration and Health Care Financing Administration; not consistent with currently accepted medical practice; not legally obtainable; or not proven safe and effective.

**Home Health Agency:** means a public agency or private organization, or a sub-division of such an agency or organization, which: (1) is primarily engaged in providing skilled nursing services and other therapeutic services; (2) has policies established by a group of professional personnel (associated with the agency or organization), including one or more Physicians and one or more registered professional Nurses, to govern the services which it provides, and provides for supervision of such services by a Physician or registered professional Nurse; (3) maintains clinical records on all patients; (4) in the case of an agency or organization in any State, in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (a) is licensed pursuant to such law, or (b) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing; and (5) meets such other conditions of participation as are established under the Medicare program in the interest of the health and safety of individuals who are furnished services by such agency or organization.

**Home Health Aide:** means a person who: (1) provides care of a medical or therapeutic nature; and (2) reports to and is directly supervised by a Home Health Care Agency.

**Home Health Care Plan:** means one that meets these standards: (1) a Physician must establish and approve the plan in writing; and (2) the plan must cover a condition that would otherwise require Confinement in a Hospital or convalescent nursing home.

**Hospice:** means care for an Insured Person who has a terminal illness resulting in a life expectancy of six months or less; the care must be recommended by the attending Physician.

**Hospital:** means a licensed institution which is legally constituted and operated in accordance with the laws pertaining to hospitals in the jurisdiction where it is located, and which meets all of the following requirements: (1) it is engaged primarily in providing medical care and treatment to sick and injured persons on an Inpatient basis at the patient's expense; (2) it provides 24-hour-a-day nursing service by registered, graduate Nurses; (3) it is under the supervision of a staff of duly licensed Physicians; (4) it provides organized facilities for diagnosis and for major operative surgery either on its premises or in facilities available on a prearranged basis; and (5) it is not primarily a clinic, nursing home, rest or convalescent home, extended care facility, Hospice or similar establishment nor, other than incidentally, a place for persons with mental or nervous disorders, the aged, alcoholics or drug addicts. Confinement in a special unit of a Hospital used primarily as a nursing, rest, or convalescent home shall be deemed, for the purposes of This Policy, to be Confinement in an institution other than a hospital.

**Immediate Family:** means: (1) the parent, spouse, brother, sister or children of the Insured Person; (2) a resident in the Insured Person’s household, or the Insured Person’s employer; or (3) any person related to the Insured Person by blood, marriage or legal adoption.

**Injury:** means bodily harm resulting from an Accident and is independent of all other causes.

**Inpatient:** means Confinement in a Hospital as a Registered Bed-Patient for a minimum of 18 consecutive hours for which room and board charges are made.

**Insured Person:** means the person who holds this Policy, and his eligible Spouse and Dependents who meet the Eligibility Requirements and have paid the required premium.

**Intensive Care Unit:** means a section, ward or wing within a Hospital which is separated from other Hospital facilities and: (1) is operated exclusively for the purpose of providing professional care and treatment for critically ill patients; (2) has special supplies and equipment necessary for such care and treatment which are available on a standby basis for immediate use; (3) provides room and board, and constant observation by registered graduate professional Nurses or other specially trained Hospital personnel; and (4) is not maintained for the purpose of providing normal postoperative recovery treatment or service.

**Loss:** means medical Expense sustained by an Insured Person that is covered by this Policy.

**Medically Necessary:** means a Confinement, service or supply that We determine meets each of these requirements: (1) it is ordered by a Physician for the diagnosis or the treatment of a Sickness or Injury deemed eligible within the language of this Policy; (2) for services or supplies, and the prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that omission would adversely affect the Insured Person's medical condition; (3) for Hospital Confinement, and the prevailing opinion within the appropriate specialty of the United States medical profession is that Inpatient acute care Confinement is necessary and any lesser level of care would adversely affect the Insured Person's medical condition; and (4) it is furnished by a provider with appropriate training, experience, staff and facilities to furnish that particular service or supply.

**Nurse:** means a licensed registered graduate professional nurse (R.N.) or a licensed practical nurse (L.P.N.) who is under the direction of a Physician. The term nurse does not include the Insured Person, the Insured Person's Immediate Family, or the Insured Person's Employer.

**Outpatient:** means services rendered or charges incurred by a patient at a healthcare facility, including but not limited to, a Hospital, clinic, or Ambulatory Surgical Facility without a stay or admission of 18 consecutive hours or more.

**Overall Maximum Benefit Payable:** means the maximum aggregate amount of benefits payable under the Policy for an Insured Person for Eligible Expenses. It is shown in the Schedule of Benefits.

**Physical Medicine:** means treatment of a disease by physical agents such as: heat, cold, light, electricity, manipulation or the use of mechanical devices.

**Physician:** means a licensed practitioner of the healing arts who is practicing and treating within the scope and limitations of that license. The term Physician includes licensed Audiologist/Speech-Language Pathologist, Chiropractors, Dentists, Nurse Anesthetists, Optometrists, Podiatrists, Psychologist or Physician Assistant whose practice complies with the laws of Arkansas. The term Physician will not include the Insured Person, the Insured Person's Immediate Family, or the Insured Person's employer.

**Policy:** means the contract issued to the Insured Person providing the benefits described herein.

**Pre-Existing Conditions:** means any condition or complication thereof, that required medical treatment, advice, consultation, or Expense during the 36 months immediately before the Insured Person's Effective Date of insurance; or which produces symptoms within the 36 months immediately prior to the Insured Person's Effective Date of insurance. These symptoms must be significant enough to establish manifestation or onset by one of the following tests: (1) they would allow a Physician to make diagnosis of the disorder; or (2) they would cause a reasonable person to seek diagnosis or treatment.

**Pregnancy:** means normal pregnancy, normal childbirth or elective cesarean section.

**Prescription Drugs:** means: (1) a legend drug; (2) injectable insulin prescribed by a Physician; (3) a compounded drug of which at least one part is a legend drug; or (4) any other drug that, under state law, may only be dispensed upon the written prescription of a Physician. It does not include an oral contraceptive for prevention of Pregnancy.

**Professional Review Organization:** means or refers to an organization selected by Us that provides a program of medical review services under Physicians, Nurses and record technicians.

**Registered Bed-Patient:** means an individual who, while Confined to a Hospital, is assigned to a bed in any department of the Hospital, and for whom a charge for room and board is made by the Hospital.

**Semi-Private Room:** means a room with at least two beds in a Hospital.

**Semi-Private Room Rate:** means: (1) the facility's most common daily charge for room and board for a Semi-Private Room; or (2) if the facility does not have Semi-Private Rooms, 80% of its daily charge for room and board for its lowest rate private room.

**Sickness:** means an illness, disease or infection, except Pregnancy. It includes Complications of Pregnancy only: (1) during Confinement in a Hospital; and (2) if conception occurred after the Insured Person's Effective Date. Complications of Pregnancy will be automatically included if birth occurs at least 270 days after the person's Effective Date. With respect to Dependent Children who automatically

become insured under the Policy at birth, the term "Sickness" shall also include medically diagnosed congenital defects and birth abnormalities.

**Skilled Nursing Facility:** means an institution, or distinct part of an institution, which is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care and treatment for persons convalescing from Injury or Sickness and: (1) is approved by and is a participating Skilled Nursing Facility of Medicare; (2) has organized facilities for medical treatment and provides 24-hour-a-day nursing service under the full-time supervision of a licensed Physician or of a registered graduate professional Nurse; (3) maintains daily clinical records on each patient and has available the services of a licensed Physician under an established agreement; (4) provides appropriate methods for dispensing and administering drugs and medicines; (5) has transfer arrangements with one or more Hospitals, a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group including at least one licensed Physician; and (6) is not, other than incidentally, a rest home for the aged, or a place for the treatment of mental disease, drug addiction or alcoholism.

**Sound Natural Tooth:** means a tooth that is natural, whole, vital and free of disease.

**Spinal Manipulation Or Adjustment:** means the treatment of: (1) of any bodily ailment, complaint, pain or Injury, including rehabilitation or treatment related to loss of bodily part, peripheral nerves, spinal cord or musculoskeletal or other soft tissue Sickness or Injury; and (2) by various physical, manual or mechanical means, including the use of heat, cold, light, sound, water, exercise, massage, manipulation, electric current or any other Physical Medicine service or procedure.

**Spouse:** means Your lawful spouse, who is not legally separated from You, and is under age 65 at the time of application. It does not include a common law spouse.

**Total Disability Or Totally Disabled:** means the Insured Person is prevented by reason of Injury or Sickness from engaging in his own occupation for wage or profit and any occupation to which he is suited by talent or education. A Dependent is considered to be totally disabled when he is prevented by reason of Injury or Sickness from engaging in all normal activities of a person of like age and sex in good health.

**Usual And Customary:** means a charge which is: (1) made by a Physician or supplier of services, medicines, or supplies; and (2) the customary charges made by others rendering or furnishing such services, medicines or supplies within an area in which the charge is incurred for Sickness or Injury comparable in severity and nature to the Injury or Sickness being treated. The term "area" as it would apply to any particular service, medicine or supply, means a county or such greater area as is necessary to obtain a representative cross section of level of charges.

**We, Us, or Our**: means Markel Insurance Company.

**You, Your, or Yourself:** means the Insured Person.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *MRKC-126222233* | *State:* | *Arkansas* |
| *Filing Company:* | *Markel Insurance Company* | *State Tracking Number:* | *42899* |
| *Company Tracking Number:* | *MISTM100-AR (07/09)* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.004 Short Term* |
| *Product Name:* | *Short Term Medical Insurance* | | |
| *Project Name/Number:* | *Short Term Medical Insurance/MISTM100-AR (07/09)* | | |

# Rate Information

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *MRKC-126222233* | *State:* | *Arkansas* |
| *Filing Company:* | *Markel Insurance Company* | *State Tracking Number:* | *42899* |
| *Company Tracking Number:* | *MISTM100-AR (07/09)* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.004 Short Term* |
| *Product Name:* | *Short Term Medical Insurance* | | |
| *Project Name/Number:* | *Short Term Medical Insurance/MISTM100-AR (07/09)* | | |

# Supporting Document Schedules

**Satisfied -Name:** Flesch Certification

**Review Status:** Approved-Closed 07/13/2009

**Comments:**

**Attachment:**

AR Flesch Certification.pdf

**Satisfied -Name:** Application

**Review Status:** Approved-Closed 07/13/2009

**Comments:**

MISTM123, approved on 06/18/2008 (SERFF Tracking Number MRKC-125633664, State Tracking Number 39198)

**Satisfied -Name:** Health - Actuarial Justification

**Review Status:** Approved-Closed 07/13/2009

**Comments:**

STM Actuarial Memorandum - 2007, approved on 06/18/2008 (SERFF Tracking Number MRKC-125633664, State Tracking Number 39198)

**Satisfied -Name:** Outline of Coverage

**Review Status:** Approved-Closed 07/13/2009

**Comments:**

Outline of Coverage, approved on 06/18/2008 (SERFF Tracking Number MRKC-125633664, State Tracking Number 39198)

**Satisfied -Name:** Red-Lined Document Reflecting Changes

**Review Status:** Approved-Closed 07/13/2009

**Comments:**

The attachment reflects changes to the document from the version approved on 06/18/2008.

**Attachment:**

MISTM100-AR 06-08 Red-Lined.pdf

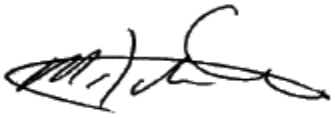
# MARKEL INSURANCE COMPANY

4600 Cox Road Glen Allen, Virginia 23060-9817 P.O. Box 3870, Glen Allen, Virginia 23058-3870
(804) 527-2700 (800) 431-1270 Fax (804) 527-7915


## FLESCH READABILITY CERTIFICATION

The form listed below does not meet the minimum reading score established by the State of Arkansas, but qualifies to be exempt under 23-80-207. The form includes language consisting of medical terminologies typical of the Accident and Health Policy.

| FORM NUMBER | FLESCH SCORE |
|---|---|
| MISTM100-AR (07/09) | 36.3 |



_____ 07/09/2009

Mark Nichols Date
Vice President
Markel Insurance Company

# MARKEL INSURANCE COMPANY
# Deerfield, IL

## INDIVIDUAL POLICY
## SHORT TERM MEDICAL INSURANCE

Policy Number: [12345]
Policy Date: [Month, Day, Year]

Policyholder: John Smith

The Policy will be administered on Our behalf by the "Administrator:" [ABC Administrator]

This Policy is delivered in Arkansas and shall be governed by the laws thereof.

The consideration for this Policy is Your Application and the payment of premiums as provided in the Policy. This Policy and Your attached Application constitute the entire contract. Only an executive officer of Markel Insurance Company can authorize a change of the Policy or Benefits.

**10 DAY RIGHT TO RETURN THE POLICY**

If for any reason You are not satisfied with this Policy, You may return it to Markel within 10 days after You receive it. We will refund any premium paid and the Policy will be deemed void, just as though it had not been issued.

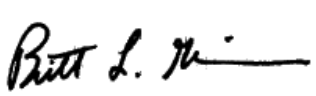
**THIS IS NON-RENEWABLE SHORT-TERM INSURANCE AND MAY NOT BE RENEWED AT THE END OF THE COVERAGE PERIOD. PLEASE READ ALL DOCUMENTS CAREFULLY.**

**Policyholder Service Office of Company:** [SASid Insurance Development]
**Address:** [462 Midland Road, Janesville, WI, 53546]
**Telephone**: [1-800-279-2290]
**Claims Service Office of Company:** [International Funding, Ltd.]
**Address:** [1 South Pinckney Street, Suite 800, Madison, WI 53703]
**Telephone:** [1-800-610-1920]

If we at Markel Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

**Arkansas Insurance Department**
**Consumer Services Division**
**1200 West Third Street**
**Little Rock, AR 72201-1904**
**Telephone: (501) 371-2640 or 1-800-852-5494**

**Markel Insurance Company**



President

Secretary



Deleted: 06/08

**INDEX**





Deleted: 06/08

## SCHEDULE OF BENEFITS

**Coverage is provided under Policy Number: [12345] [ABC PLAN #]**

**Issued to Policyholder: [John Smith]**

Coverage Period: [30 – 185 days] or [365 days]
Effective Date:
Expiration Date:

The premium payable for this insurance is on file with the Administrator and Markel Insurance Company.

Premium Payment Intervals available to Insured Persons: [Monthly/Quarterly/Semi-Annually/Annually]

Premium Due Date: The Effective Date and the first day of each succeeding interval.

Hospital admissions and lengths of stay are subject to pre-certification by a Professional Review Association as stated below:

### PRE-ADMISSION CERTIFICATION NOTICE:

This Policy requires a Pre-Admission Certification by a "Professional Review Organization" prior to Inpatient hospitalization or surgery of an Insured Person as follows:

(a) Ten days prior to a non-emergency hospitalization; surgical procedure; or
(b) Within 48 hours or on the first business day following an Emergency admission; or
(c) Within 48 hours of delivery for complicated childbirth.

The Professional Review Organization shall review the applicable information and determine the following:

(a) Medical necessity of the Inpatient hospitalization and/or surgical procedure to be performed;
(b) The appropriate length of stay; and
(c) Any appropriate extension(s) of the length of stay beyond that which was initially certified.

The Professional Review Organization's purpose is to determine medical necessity only. A determination of medical necessity does not guarantee or imply benefits at any time. All Inpatient hospitalizations and/or surgical procedures are subject to the Limitations and Exclusions of the Policy.

Non-compliance with the Pre-Admission Certification procedure will result in a reduction in benefits to the lesser of: $1,000; or 50% of the Eligible Expense. This penalty will be taken no more frequently than once per Inpatient hospitalization or surgery, unless the Insured Person is incapacitated and unable to contact Us. In such cases, a representative of the Insured Person, their legal agent, or the provider of service must contact Us as soon as possible.

Information and procedures necessary for Pre-Admission Certification have been issued to each Insured Person. An Insured Person may obtain more information regarding Pre-Certification and its procedures from the Administrator.

The Deductible Amount, Coinsurance Percentage Payable, Coinsurance Limit, and Overall Maximum Benefit Payable amount(s) are applicable to each Insured Person and for all benefits unless specifically noted elsewhere in the Policy.



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**[DEDUCTIBLE AMOUNT PER COVERAGE PERIOD:**

| | |
|---|---|
| For all Eligible Expenses, with the exception of Mammograms and Pap Smears: | [$250 - $5000] per person, per Coverage Period. |
| Mammograms and Pap Smears: | Not subject to the Deductible, only Coinsurance Percentage Payable is applicable.] |

[OR]

**DEDUCTIBLE AMOUNT PER CAUSE:**

| | |
|---|---|
| For all Eligible Expenses with the exception of Mammograms and Pap Smears: | [$250 - $1000] per person, per cause, as elected. |
| Mammograms and Pap Smears: | Not subject to the Deductible |

If You elect the Per Cause Deductible, You must satisfy Your elected Deductible Amount for each incident or subsequent incidents for the same Injury or Sickness before any other Eligible Expenses will be paid for such incident.]

| | |
|---|---|
| **COINSURANCE LIMIT: (Out of Pocket Limit)** | $10,000 per person, per Coverage Period, subject to the Overall Maximum Benefit Payable. |

**COINSURANCE PERCENTAGE PAYABLE: (After satisfaction of the Deductible Amount)**

| | |
|---|---|
| For all conditions, unless specifically noted elsewhere in the Policy: | [50% - 100%] of Eligible Expenses up to the Coinsurance Limit.<br>Thereafter, [80% - 100%].<br>All Eligible Expenses are subject to Usual and Customary Charges and the Overall Maximum Benefit Payable. |

| **HOSPITAL INPATIENT DAILY ROOM RATE:** | **MAXIMUM BENEFIT PAYABLE:** |
|---|---|
| A. For normal care: | The Average Semi-Private Room Rate |
| B. For Intensive Care: | [1 – 3] times the Average Semi-Private Room Rate |
| **SURGEON:** | Professional Fees Payable |
| **ASSISTANT SURGEON/CO-SURGEON:** | Up to 20% of the lead surgeon's allowable benefit. |
| **SURGEON'S ASSISTANT**: | Up to 15% of the lead surgeon's allowable benefit. |



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| | |
|---|---|
| **ANESTHESIOLOGIST:** | Up to 20% of the lead surgeon's allowable benefit. |
| **PRIVATE DUTY NURSING**: | |
| Maximum Rate: | $75 per 8 hour shift |
| Maximum Payment Period: | 90 shifts per Coverage Period |
| **SKILLED NURSING FACILITY**: | |
| Maximum Daily Room Rate: | $30 per day |
| Maximum Payment Period | 30 days per Coverage Period |
| **GROUND AND AIR AMBULANCE SERVICES**: | |
| Maximum Benefit: | $250 per trip. |
| **ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) and HUMAN IMMUNE DEFICIENCY VIRUS (HIV) related illness:** | |
| Maximum Benefit: | $10,000 per person per Coverage Period |
| **HUMAN ORGAN and TISSUE TRANSPLANTS:** | |
| Maximum Benefit: | $125,000 per person per Coverage Period |
| **SPINAL MANIPULATION or ADJUSTMENT:** | |
| Maximum Benefit: | $1,000 per person per Coverage Period |
| **OUTPATIENT PHYSICAL THERAPY SERVICES:** | |
| Maximum Benefit: | 12 visits per person per Coverage Period |
| **HOME HEALTHCARE VISITS and SERVICES:** | |
| Maximum Benefit: | 40 visits per person per Coverage Period<br>$40 per 8 hour shift |
| **HOSPICE CARE and SERVICES:** | $5,000 per person per Coverage Period |
| **COLORECTAL CANCER SCREENING:** | $300 per person per Coverage Period |
| **DENTAL ANESTHETIC SERVICES:** | $250 per person per Coverage Period |
| **OVERALL MAXIMUM BENEFIT PAYABLE (includes all conditions, all benefits):** | $1,000,000 per person per lifetime. |



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## ELIGIBILITY AND EFFECTIVE DATES

### ELIGIBILITY - WHO IS ELIGIBLE

**EE-10 YOU**

You will be eligible for insurance on Yourself as long as:

(1) You are at least 2 years of age but less than 65 years of age.
(2) You are not covered as a Dependent under another group policy.
(3) You are not pregnant or are an expectant father at the time of application.
(4) You are required to have a social security number.
(5) You are not a member of the armed forces.
(6) You submit a written application for insurance; provide Evidence of Insurability, if evidence is required; and meet Our Enrollment and Underwriting Requirements.
(7) You pay all required premiums when due.

**EE-20 YOUR SPOUSE AND DEPENDENT CHILDREN**

You will be eligible to apply for insurance for Your Spouse and Dependent Children who:

(1) Meet the definitions of Spouse and Dependent Children.
(2) Are not pregnant at the time of application.
(3) Are not members of the armed forces.
(4) For whom a written application for insurance and Evidence of Insurability, if required by Us, has been approved, and each meets Our Enrollment and Underwriting Requirements.

If You and Your Spouse are both covered as Insured Persons, only one parent will be eligible for insurance on any Dependent Children You may have.

**EE-30 ENROLLMENT REQUIREMENTS**

You and Your Spouse and Dependent Children who desire coverage must complete and submit an application and provide any other documents (including Evidence of Insurability) as deemed necessary by Us. You must submit the required premium with Your application form. Any misrepresentation or omission of information in Your application or any documents submitted to Us may result in rescission of all coverage for all Insured Persons.

**EE-40 UNDERWRITING REQUIREMENTS**

All Insured Persons are subject to Our underwriting requirements. We reserve the right to accept or decline any applicant at Our discretion. Our underwriting requirements will be as determined by Us.

**EE-50 ADDITIONAL CONDITIONS**

Insurance on any Insured Person will not be effective unless all Eligibility Requirements are met and You receive written acceptance from Us. Insurance on an Insured Person will not be effective unless premium is paid and accepted by Us for such insurance. You will be insured for coverage on Your dependents only if You are an eligible Insured Person. Issuance of a Policy is not a waiver of any of the above conditions.

## EFFECTIVE DATES

**ED-10 YOU**

Coverage is effective on You, and Your Spouse and Dependent Children who were included in Your initial application form, as of the Effective Date shown in Your Schedule of Benefits, provided that You meet Our Eligibility, Underwriting and Enrollment requirements. Coverage will not become effective for any applicant whose medical history changes prior to coverage



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approval, such that the applicant's answer would be "Yes" to any of the medical history questions in the application if such applicant is the Insured Person, coverage is automatically declined for all persons included in the application.

**ED-20 ADDITIONS**

You may desire to apply for coverage for a previously uncovered Spouse or Dependent Child. To do so, the following requirements must be met:

(1) You must complete and submit to Us for approval, an application form for such Spouse or Dependent Child.
(2) Such person must meet Our Eligibility, Underwriting and Enrollment Requirements.
(3) You must pay any additional premium, if approved for coverage.

**ED-30 EXCEPTIONS**

**Newborn Dependent Children**

Coverage for newborn Dependent Children will become effective at birth and remain in force only for 90 days. For coverage to continue, We must be notified of the birth of such newly born Dependent Child in writing within 90 days after the date of birth. If such notice is not received within the 90-day period, a later application will be subject to Our Underwriting Requirements. If approved, coverage for the newborn will not be effective until the first of the month following such approval by Us.

**Children Pending Adoption:**

Coverage for a child for whom a petition for adoption has been filed, will become effective from the date the petition is filed, if coverage is applied for within 60 days of such filing. Coverage for an adopted newborn child is from the moment of birth, if applied for within 60 days after birth. Coverage ceased upon the dismissal or denial of a petition for adoption.

**ED-40 WHEN CHANGES IN COVERAGE OCCUR:**

Any change in benefits which occurs automatically under the Policy provisions or Schedule of Benefits will become effective on the date that the status of the Insured Person changed.

Any request for an increase or decrease in either benefits or coverage is subject to the approval of Our Administrator or Us. Should changes in coverage be requested, such changes shall not become effective until the first premium due date following the date of the Administrator's or Our written approval.

If any requested change increases benefits or coverage, the effective date of the increase will be delayed for an Insured Person who is confined for medical treatment in an institution. The delay will end and the increase shall become effective on the day following his final medical discharge from such Confinement.

## TERMINATION OF INSURANCE

**T-10 TERMINATION OF AN INSURED PERSON'S INSURANCE:**

Your insurance will automatically terminate on the earliest of the following dates:

(1) The date that Your Policy terminates.
(2) The due date of a premium payment that is not paid when due, if such payment has not been made within 31 days following such premium due date.
(3) The date that We determine fraud or material misrepresentation has been made by You or with Your knowledge in filing a claim for benefits under the Policy.
(4) The date that You enter full-time active duty in the armed forces of any country or international organization.
(5) The date You become eligible for Medicare.



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(6) The earlier of: (1) the date Your elected Coverage Period expires; or (2) [3,6,12 months] from Your Effective Date of insurance, whichever occurs first.

**T-20 TERMINATION OF AN INSURED DEPENDENT'S INSURANCE:**
An insured Dependent's insurance will automatically terminate on the earliest of the following dates:

(1) The date that his Policy terminates.
(2) The due date of a premium payment that is not paid when due, if such premium payment has not been made within 31 days following such premium due date.
(3) The date that the Dependent's insurance under the Policy is discontinued.
(4) The date that We determine fraud or material misrepresentation has been made by the Insured Person or insured Dependent or with the Insured Person's or insured Dependent's knowledge in filing a claim for benefits under the Policy.
(5) The date that the Insured Person's insurance terminates, except if termination is due to the Insured Person's death, an insured Dependent Spouse may elect to continue coverage for insured Dependents for the duration of the Coverage Period by making written request for such coverage and by continuing payments toward the cost of that insurance. When such an election is made, the Spouse will be considered the Insured Person under the terms of the Policy.
(6) The date the Insured Person or insured Dependent becomes eligible for Medicare.
(7) The date that he ceases to be an eligible Dependent, except that, if upon attaining any limiting age, a Dependent Child is mentally or physically incapable of earning his own living and is chiefly dependent upon the Insured Person for support and maintenance, benefits with respect to said Dependent may be continued on a premium paying basis during the continuance of such incapacity, provided that: (a) proof, in writing, of such incapacity has been given to Us when the Dependent child attains the limiting age or (b) We shall have the right during continuance of insurance to require due proof of the continuance of the incapacity and to have the Dependent child examined by Physicians designated by Us. The continuance of insurance as described herein, shall cease in the event: (1) of the termination of the Policy; or (2) of the termination of the Insured Person's insurance; or (3) of the discontinuance of Dependent's insurance under the Policy.
(8) The earlier of: (1) the date the Insured Person's elected Coverage Period has expired; or (2) [3] [6] [12] months from the Effective Date of the Insured Person's insurance, whichever occurs first.

## PREMIUMS

**P-10** The premiums applicable with respect to individual persons insured under the Policy are on file with the Administrator and Us. Any references to age shall refer to the person's attained age on any premium due date. The first premium due date shall be the Policy Effective Date. Subsequent premiums are due as noted in the Policy. All premiums paid to Our Administrator or Us will be fully earned at the time of payment and no premium will be refunded unless the Insured Person elects to terminate their coverage within ten days of issuance/receipt of their Policy.

**P-20** We reserve the right to change the rates on any premium due date on or after the first Policy Anniversary Date. 30-days advance written notice of any such change must be given to the Insured Person.


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**M-10 WHAT IS COVERED:**

If an Insured Person incurs Expenses for medical diagnosis, treatment, supplies or services, as a result of Injury or Sickness which occurs while his insurance under the Policy is in effect, We will pay the Coinsurance Percentage Payable, shown in the Schedule of Benefits, of all Eligible Expenses incurred during a Coverage Period in excess of the Deductible Amount, subject to the Limitations and Exclusions of the Policy and the Overall Maximum Benefit Payable.

**M-20 ELIGIBLE EXPENSES:**

Eligible Expenses are subject to a determination of Medically Necessary, Usual and Customary Charges, and Pre-Admission Certification, provided that they are not limited or excluded under Limitations and Exclusions. Eligible Expenses include the following:

(1) **HOSPITAL CHARGES** -
- (a) Room and board for Confinement in a Semi-Private Room, up to the Hospital's average Semi-Private Room Rate;
- (b) Room and board for Confinement in an Intensive Care Unit, Cardiac Unit, or other similar licensed Inpatient unit except unless specifically noted;
- (c) Medical services performed and supplies used during Confinement; and
- (d) Outpatient services performed and supplies used with the exception of individual professional fees.

(2) **AMBULATORY SURGICAL CENTER CHARGES** – Treatment in an Ambulatory Surgical Center for medical care, but only if the charges are made for a condition that would normally require Hospital care.

(3) **SKILLED NURSING FACILITY CONFINEMENT CHARGES** – Treatment in a Skilled Nursing Facility for room and board while the Insured Person is continuously Confined as a Registered Bed-Patient. The Confinement must start within 14 days after the end of a Medically Necessary Hospital Confinement of at least three consecutive days. The Confinement must be ordered by a Physician to convalesce from the Sickness or Injury that caused the prior Hospital Confinement. If, within 14 days after the end of a Skilled Nursing Facility Confinement, the Insured Person is again Confined for the same cause as for the prior Confinement, both Confinements will be deemed to be continuous and eligible for consideration of benefits.

(4) **PHYSICIAN, SURGEON, and ANESTHESIOLOGIST CHARGES** – Treatment by a duly licensed Physician for diagnosis, treatment, and surgery.

(5) **NURSING CHARGES** – Treatment by a registered graduate Nurse (R.N.) or licensed practical Nurse (L.P.N.). The charges must be for nursing care.

(6) **PHYSICAL MEDICINE CHARGES** – Treatment for rehabilitative services, including but not limited to those for occupational, physical, rehabilitative, and speech therapies. Also included is Medically Necessary preventative physical therapy for multiple sclerosis. These services must include a prescriptive care plan from a treating or referring Physician and be performed by a duly licensed Physician, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Licensed Speech Therapist (L.S.T.), or Licensed Physical Therapist (L.P.T).

(7) **HOME HEALTH AGENCY CHARGES** – Treatment by a Home Health Agency for the following treatments, services and supplies when they are furnished to a person in accordance with a Home Health Care Plan. The Plan must be implemented within 14 days



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after the end of a Medically Necessary Hospital Confinement, as a Registered Bed-Patient, of at least five consecutive days:

(a) Part-time or intermittent services of a Home Health Aide;

(b) Part-time or intermittent nursing care furnished, or supervised by a registered graduate Nurse (R.N.); but only if the charge is not also claimed as an Eligible Expense under (5) above;

(c) Physical, occupational or speech therapy; but only if the charge is not also claimed as an Eligible Expense under (6) above.

(d) Laboratory services by, or on behalf of, a Home Health Agency and medical supplies and Prescription Drugs which can be lawfully dispensed only by a licensed pharmacy at a Physician's written prescription; to the same extent that benefits for these services, supplies and Prescription Drugs would have been available to the Insured Person if he were then Confined as a Registered Bed Patient in a Hospital or convalescent nursing home.

Each visit by an employee of a Home Health Care Agency will count as one visit. Each four hours of service by a Home Health Aide will count as one visit. Not included are charges for: (a) domestic or housekeeping services unrelated to patient care; (b) home food services; (c) Mental/Nervous Disorder; (d) rental or purchase of renal dialysis equipment or supplies; or (e) nursing home or Skilled Nursing Facility care. The Insured Person must be under the continuing care of a Physician during the period of his Home Health Care Plan.

(8) **HOSPICE CARE AND SERVICES** – Treatment and services provided by a licensed Hospice provider to a terminally ill Insured Person with a life expectancy of six months or less. Eligible Expenses will include, but are not limited to the following:

(a) Part-time or intermittent home nursing care by or under the direction of a licensed Nurse;

(b) Physical, respiratory, or speech therapy performed by a licensed therapist;

(c) Counseling by a licensed social worker or pastoral counselor for the Insured Person, a member of the Insured Person's immediate family, the primary care giver, and individuals with significant personal ties to the Insured Person who is terminally ill.

Hospice services must be:

(a) Under active management through an agency licensed or certified to provide hospice services and which is responsible for coordinating all such services; and

(b) Provided only when the Physician has submitted written certification to Us that the Insured Person is terminally ill with a life expectancy of six months or less. Periodic reviews of medical necessity may be necessary.

This benefit does not include the services of volunteers or persons who do not regularly charge for their services.

(9) **SPINAL MANIPULATION OR ADJUSTMENT** - Treatment by a Physician or Licensed Doctor of Chiropractic for physical manipulation involving the spine; traction; inversion therapy; hot or cold packs; electrical stimulation therapy; diathermy; therapeutic exercise; neuromuscular reeducation; gait training; thermography; biofeedback therapy; hydrocollar therapy; passive motion therapy; and office visits, consultations; x-rays, laboratory and other diagnostic studies performed in connection with spinal manipulations and spinal adjustments, or spinal therapy. Charges for massage therapy are considered only when performed by a Licensed Physical Therapist or Physician in conjunction with treatment intended to rehabilitate Injury or Sickness related to loss of limb(s), damage to peripheral nerves, spinal cord, musculoskeletal system, or other soft-tissue Injury.



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(10) **MAMMOGRAPHY/PAP SMEAR** – Coverage is provided for the Expense for screening by low-dose mammography for the presence of occult breast cancer for all women age 35 and older, inclusive of the following:

(a) A baseline mammogram for women 35 to 40 years of age;
(b) An annual mammogram for women 40 years of age or older; and
(c) A mammogram at intervals considered Medically Necessary by the woman's health care provider for women having a history of breast cancer or other risk factors.
(d) One routine cervical cytologic screening for women.

Such charges will be exempt from any Deductible Amount applicable under the Policy.

(11) **BONE MASS MEASUREMENT AND OSTEOPOROSIS** – Coverage is provided for bone mass measurement and for the diagnosis and treatment of osteoporosis.

(12) **HUMAN ORGAN AND TISSUE TRANSPLANTS** - Hospital, Physician and medical supply charges for non-Experimental human organ and/or tissue transplants or replacements.

(13) **SERVICES AND SUPPLIES:**
(a) X-ray exams and microscopic and laboratory tests and analyses.
(b) Anesthesia, oxygen and their administration.
(c) Diagnostic imaging, radioactive isotope therapies, and other therapeutic services using x-ray or radiation.
(d) Blood or blood derivatives and their administration.
(e) Casts, splints, trusses, braces or crutches but not their replacement or repair; surgical dressing or artificial limbs or eyes excluding repair or replacement of lost items.
(f) Prescription or legend drugs which are administered during a Hospital Confinement and dispensed only by a licensed pharmacy and which a Physician prescribes in writing to treat a specific Injury or Sickness. Off-Label drugs not approved by the US Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved are covered provided: (i) the drug has been recognized as safe and effective for treatment of that specific type of cancer in the American Hospital Formulary Service drug information or the United States Pharmacopoeia dispensing information; (ii) the drug has been recognized as safe and effective for treatment of that specific type of cancer in two articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature.
(g) Rental of an iron lung or other mechanical equipment to treat respiratory paralysis; rental of a wheelchair or Hospital bed; or equipment to administer oxygen; not to exceed purchase price.
(h) Transportation of the Insured Person needing treatment by a professional ground or air ambulance to a local Hospital, only if the condition so requires**.**

(14) **CHILD PREVENTIVE HEALTH CARE SERVICES** - Benefits are covered for periodic preventive care visits from the moment of birth until the age of 18. Such services rendered during a periodic review will only be covered to the extent that those services are provided by or under the supervision of a single Physician during the course of one visit.

Benefits shall be limited to one visit payable to one provider for all of the services provided at each visit cited in this section. Physical exams that are required by third parties are not covered. All charges are subject to the Deductible Amount. Benefits for vaccines and immunizations are exempt from any Deductible Amount, Coinsurance Percentage or dollar limits.


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"Children's Preventive Health Care Services" means physician-delivered or physician-supervised services from birth to age 18, with 20 Periodic Preventive Care Visits, including medical history, physical examination, development assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards.

"Periodic Preventive Care Visits" means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practices.

(15) **COLORECTAL SCREENING** –Benefits are covered for colorectal screenings for:

(a) Individuals over 50 years of age or who face a high risk for colorectal cancer because of: (i) The presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy; (ii) A family history of colorectal cancer in close relatives of parents, brothers, sisters, or children; (iii) Genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis; (iv) A personal history of colorectal cancer, ulcerative colitis, or Crohn's disease; or (v) The presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and

(b) Any additional or expanded definition of "persons at high risk of colorectal cancer" as recognized by medical science and determined by the Director of the Division of Health of the Department of Health and Human Services in consultation with the University of Arkansas for Medical Sciences.

(16) **DIABETES** – Benefits are covered for treatments, including, but not limited to, equipment, supplies used in the monitoring of blood glucose and insulin administration and Diabetes Self-management Training.

"Diabetes self-management training" means instructions in an inpatient or outpatient health setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding programs the primary purposes of which are weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

(17) **IN VITRO FERTILIZATION** – Benefits are covered for services performed at a medical facility, licensed or certified by the Department of Health, those performed at a facility certified by the department that conforms to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics, or those performed at a facility certified by the department that meets the American Fertility Society minimal standards for programs of in vitro fertilization.

(18) **LOSS OR IMPAIRMENT OF SPEECH OR HEARING** - Benefits are covered for the necessary care and treatment of loss or impairment of speech or hearing, subject to the same deductible, coinsurance and limits as other covered services in the Policy.

"Loss or impairment of speech or hearing" shall include those communicative disorders generally treaty by a licensed speech pathologist or audiologist.

(19) **MUSCULOSKELETAL DISORDERS OF FACE, NECK OR HEAD** – Benefits are covered for Medically Necessary diagnosis and medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head including temporomandibular joint disorder and craniomandibular disorder.



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(20) **PKU/MEDICAL FOODS & LOW PROTEIN MODIFIED FOOD PRODUCTS** – Benefits are covered for low protein modified food product and medical food for the treatment of inherited metabolic disease.
"Low protein modified food product" means a food product that is specifically formulated to have less than one gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease."

"Medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician."

(21) **PROSTATE CANCER SCREENING** – Coverage is provided for the Expense for screening performed by a qualified medical professional for the early detection of prostate cancer in men 40 years of age and older, according to the National Comprehensive Cancer Network guidelines, as in effect on January 1, 2009, as well as a prostate specific antigen blood test recommended by a medical practitioner. Such charges will be exempt from any Deductible Amount applicable under the Policy.

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**EXPENSES INCURRED**: An Eligible Expense will be considered to be incurred at the time the service or the supply to which it relates to is provided.

**M-30 ALLOCATION AND APPORTIONMENT OF BENEFITS:**
We reserve the right to allocate the Deductible Amount to any Eligible Expenses and to apportion the payment of benefits between the Insured Person and any Insured Dependent designated by the Insured Person. Such allocation and apportionment shall be conclusive and shall be binding upon the Insured Person and all assignees.

**M-40 EXTENSION OF COVERAGE:**

An extension of coverage will be provided if an Insured Person is Totally Disabled and receiving benefits for a Hospital Confinement on the date that the Policy terminates or his coverage under the Policy terminates for reasons other than nonpayment of premium, fraud or material misrepresentation.

Benefits will be payable only for Eligible Expenses incurred in connection with the same Injury or Sickness causing the Total Disability at the time of termination. Timely payment of premium is required to continue coverage.

The extension of coverage will end on the earlier of:
(1) The date the Hospital Confinement for the Total Disability ends;
(2) The end of the 90 day period following his termination date;
(3) The date premium payment is not paid when due; or
(4) The date the Overall Maximum Benefit Payable has been paid. Benefits payable during this extension of coverage are subject to a new Deductible Amount and satisfaction of the Coinsurance Limit.
(5) The earliest date permissible by law.

## LIMITATIONS AND EXCLUSIONS

**LE-10 LIMITATIONS:** Eligible Expenses are limited by the following

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(1) Hospital Inpatient Daily Room Rate Maximum - Eligible Expenses do not include charges by a Hospital for room and board and general or floor nursing care unless they are incurred while the Insured Person is a Registered Bed-Patient. Also, they do not include any portion of such a charge in excess of the Maximum Daily Room Rate shown in the Schedule of Benefits for normal care.

(2) Hospital Inpatient Intensive Care Unit Maximum - Eligible Expenses do not include any portion of the charge made by a Hospital for care and treatment received in an Intensive Care Unit that is in excess of the Intensive Care Unit Maximum shown in the Schedule of Benefits.

(3) Private Duty Nursing Maximum - Eligible Expenses do not include charges for private duty nursing service by a registered graduate Nurse (R.N.) in excess of the Maximum Private Duty Nursing Rate and Payment Period shown in the Schedule of Benefits.

(4) Skilled Nursing Facility Maximum - Eligible Expenses do not include any portion of the charge by a Skilled Nursing Facility for room and board and general or floor nursing care in excess of the Skilled Nursing Facility Maximum Daily Room Rate shown in the Schedule of Benefits and do not include any such charges for more than the Maximum Payment Period of Skilled Nursing Facility Confinement shown in the Schedule of Benefits.

(5) Ground and Air Ambulance Services Maximum - Eligible Expenses do not include charges for ambulance transportation to a local Hospital that are in excess of the Ambulance Service Maximum shown in the Schedule of Benefits.

(6) AIDS/HIV Maximum - Eligible Expenses do not include charges in excess of the Acquired Immune Deficiency Syndrome/Human Immunodeficiency Virus Maximum shown in the Schedule of Benefits.

(7) Human Organ and Tissue Transplants Maximum - Eligible Expenses do not include charges in excess of the Human Organ and Tissue Transplant Maximum shown in the Schedule of Benefits.

(8) Spinal Manipulation or Adjustment - Eligible Expenses do not include charges in excess of the Spinal Manipulation or Adjustment Maximum shown in the Schedule of Benefits.

(9) Eye Examinations, Eyeglasses, Hearing Aids and Surgery – Eligible Expenses do not include charges incurred in connection with routine eye examinations, eyeglasses, determination of refractive states, correction or treatment of eye refractions, the purchase, fitting or adjustment of contact lenses or glasses, or treatment of cataracts, routine hearing exams to access need for or change in hearing aids, hearing aids or their fittings, Lasik, RK or other corrective vision surgery, hearing loss surgery; unless the charges are necessarily incurred to treat, within 90 days of its occurrence, an accidental bodily Injury sustained while the Insured Person was insured for this benefit and the treatment giving rise to the charges begins within 90 days after the date of the Accident causing the Injury.

(10) Dental Anesthetic Services - Eligible expenses will include those for Insured Person's in a Hospital or an Ambulatory Surgical Center if any of the following applies: (1) the Insured Person is a child age 7 or under who is determined by two licensed dentists to require immediate dental treatment in a Hospital or ambulatory surgical center; (2) the Insured Person a serious mental or physical condition; or (3) the Insured has a significant behavioral problem determined by the Insured Person's Physician.



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(11) Assistant Surgeon/Co-Surgeon, Surgeon's Assistant, Anesthesiologist – Eligible Expenses do not include charges in excess of the Assistant Surgeon/Co-Surgeon, Surgeon's Assistant, Anesthesiologist Maximum shown in the Schedule of Benefits.

(12) Hospice Care and Services - Eligible Expenses do not include charges in excess of the Hospice Care and Services Maximum shown in the Schedule of Benefits.

(13) Home Health Care Visits and Services – Eligible Expenses do not include charges in excess of the Home Health Care Visits and Services Maximum shown in the Schedule of Benefits.

(14) Outpatient Physical Therapy Services - Eligible Expenses do not include charges in excess of the Outpatient Physical Therapy Services Maximum shown in the Schedule of Benefits.

**LE-20 EXCLUSIONS:** We will not pay benefits, and charges will not accrue toward any Deductible Amount, for Expenses incurred as a result, directly or indirectly, of any of the following:

(1) [Pre-Existing Conditions, as defined.

(2) Expenses that the Insured Person is not required to pay, or those charges that would not have been billed if no insurance existed.

(3) Charges for custodial maintenance; pre-marital screenings or exams; routine services for general physical examinations; physical examinations that are required by third parties; diagnostics, screenings and research; preventative or prophylactic care; and immunizations, unless specifically noted in the Policy.

(4) Medical Expenses that are eligible for payment under an automobile medical payment benefit, regardless of fault.

(5) Injury or Sickness resulting from war, either declared or undeclared; riot or any act incidental to war or riot; while committing or attempting to commit felony; intentionally self-inflicted Injuries; suicide or attempted suicide, while sane or insane.

(6) Injury or Sickness incurred during military service or while on active duty. Upon written notice to Us of entry into active duty, any unused premium will be returned to the Insured Person on a pro-rated basis.

(7) Substance Abuse Treatment unless specifically provided by State Mandated benefits.

(8) Charges incurred by an insured Dependent who is a newborn child not yet discharged from the Hospital, unless the charges are necessarily incurred as the result of, and to treat, premature birth, congenital Injury or Sickness, or Injury or Sickness sustained during or after birth.

(9) Charges related to elective cesarean section when no complication is present or voluntary termination of a normal Pregnancy including, but not limited to, the cost of any drug, contraceptive, supply, treatment, or procedure intended to prevent conception or childbirth.

(10) Any work-related accidental bodily Injury or Sickness.



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(11) Routine charges for the care and/or treatment of a normal Pregnancy or childbirth with the exception of those Expenses related to a Complication of Pregnancy as defined in the Policy.

(12) Any services, supplies or treatment furnished by the Insured Person, an Insured Person's Immediate Family, or Employer.

(13) Services or supplies rendered to a transplant donor of any organ or bodily element or the acquisition cost of any organ or bodily element.

(14) Services related to or for the purpose of treating infertility or causing Pregnancy, including but not limited to, diagnostic testing; drugs; medicines; artificial insemination; in vitro fertilization; and embryo transplants; or any condition or complication caused by or resulting from such treatment.

(15) Participation in high-risk sports, activities, or occupations such as: skydiving; scuba diving; bungee jumping; hang gliding; or ultra light gliding; traveling in or on any all terrain vehicles such as, but not limited to: dirt bikes, all terrain vehicles, snowmobiles, or go-carts; racing with any motorcycle, boat or any form of aircraft; participation in any sports for pay or profit; participation in inter-collegiate sports; and any rodeo events.

(16) Charges that do not meet the definition or are not specifically identified under the Policy as Eligible Expenses, including amounts in excess of the Usual and Customary charges for the geographic area in which the charges are incurred.

(17) Charges determined to be for educational purposes or charges that may be provided through an educational program or facility.

(18) Voluntary inhalation or ingestion of any gas, poison or poisonous substance.

(19) Cosmetic, reconstructive or plastic surgery unless:
(a) As a result of an Injury that occurred while the Insured Person was insured under the Policy; or
(b) To correct the disorder of a normal bodily function if the disorder had its inception while the Insured Person was insured under the Policy; or
(c) Expenses are incurred for reconstructive breast surgery following a mastectomy due to illness occurring within the terms of the Policy. Reconstructive surgery includes reconstruction of the other breast to produce a symmetrical appearance if the patient elects, prostheses and physical complications in all stages of mastectomy including lymph edemas.

(20) Obesity, including any treatment, advice, consultation, medication, program or surgery recommended for reducing weight whether or not such weight reduction is recommended for reasons other than, or in addition, to, obesity; or any complication resulting from the treatment or surgery for weight reduction.

(21) Care or treatment of: weak, strained or flat feet; instability or imbalance of the foot; metatarsalgia; bunions; corns; calluses; or toenails; except for charges: (i) by a Hospital during Confinement; or (ii) for the care and treatment of a metabolic or peripheral vascular disease; or (iii) for immediate repair of Injury from an Accident that occurred while the Insured Person was insured under the Policy.

(22) Treatment related to: gender change or modification; sterilization or elective reversal of surgical procedures; breast reduction unless Medically Necessary; breast enlargement for


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any reason; or the treatment or testing for sexual dysfunction or inadequacies whether such condition has a physical or organic basis or origin.

(23) Services or supplies of a common household use, including but not limited to: exercise cycles; air or water purifiers; air conditioners; allergenic mattresses; and blood pressure kits.

(24) Charges for items or services of convenience, including but not limited to: admission kits; telephone; slippers; or homemaker services; supportive service focusing on activities of daily life such as bathing; dressing; feeding; or skin and/or bladder care; administration of oral medication or eye drops, except as specifically covered in the Policy.

(25) Experimental or investigational service, supplies, or treatments.

(26) Travel or travel expense, even though prescribed by a Physician.

(27) Outpatient Prescription Drugs; medicines; vitamins (including prenatal vitamins); mineral or food supplements; or any over the counter medicines, whether or not ordered by a Physician.

(28) Charges for the treatment of acne or varicosities of the veins.

(29) Any Expense for the treatment of Injury or Sickness occurring while intoxicated or under the influence of alcohol, illegal drugs, hallucinogenics or narcotics unless said narcotics were prescribed by a Physician and used as recommended. "Intoxicated" and "under the influence" will have the meanings determined by the laws of the jurisdiction of the geographical region in which either the Loss or the cause occurs.

(30) Charges related to transportation, except where specifically covered in the Policy.

(31) Expenses incurred to treat complications resulting from any treatment or care of conditions that are not covered under the Policy.

(32) Expenses related to diagnosing, testing for, or treating a sleeping disorder.

(33) Testing, diagnosis or treatment for or related to learning disabilities; attention deficit disorder; hyperactivity; autism; or related conditions. **]**

**HP-10** **HOSPITAL PRECERTIFICATION**

This Policy requires a Pre-Admission Certification by a "Professional Review Organization" prior to Inpatient hospitalization or surgery of an Insured Person as follows:

(a) Ten days prior to a non-emergency hospitalization; surgical procedure; or
(b) Within 48 hours or on the first business day following an Emergency admission; or
(c) Within 48 hours of delivery for complicated childbirth.

The Professional Review Organization shall review the applicable information and determine the following:

(a) Medical necessity of the Inpatient hospitalization and/or surgical procedure to be performed;



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(b) The appropriate length of stay; and
(c) Any appropriate extension(s) of the length of stay beyond that which was initially certified.

The Professional Review Organization's purpose is to determine medical necessity only. A determination of medical necessity does not guarantee or imply benefits at any time. All Inpatient hospitalizations and/or surgical procedures are subject to the Limitations and Exclusions of the Policy.

Non-compliance with the Pre-Admission Certification procedure will result in a reduction in benefits to the lesser of: $1,000; or 50% of the Eligible Expense. This penalty will be taken no more frequently than once per Inpatient hospitalization or surgery, unless the Insured Person is incapacitated and unable to contact Us. In such cases, a representative of the Insured Person, their legal agent, or the provider of service must contact Us as soon as possible.

Information and procedures necessary for Pre-Admission Certification have been issued to each Insured Person. An Insured Person may obtain more information regarding Pre-Certification and its procedures from the Administrator.

REDUCTION OF BENEFITS

To the extent that the otherwise Eligible Expense for the Hospital admission and/or length of stay and/or extensions of stay are not certified by the Professional Review Organization, We will only pay 50% of the benefits under the Policy which would otherwise have been payable for Eligible Expenses, unless the Insured Person is incapacitated and unable to contact Us. In such cases, the Insured Person must contact Us as soon as possible. No benefits will be payable under the Policy in the event such Hospital admission, length of stay or extension of stay is not Medically Necessary.

**CB-10 COORDINATION OF BENEFITS**

**I. Applicability**

A. This Coordination of Benefits ("COB") provision applies to This Plan when an Insured Person has health care coverage under more than one Plan. "Plan and This Plan" are defined below.

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

(1) Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but

(2) May be reduced when, under the order of benefits determination rules, another Plan determines its benefits first. The above reduction is described in Section IV "Effect on the Benefits of This Plan."

**II. Definitions**

A. "Plan" is any of these which provide benefits or services for, or because of, medical or dental care or treatment:


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(1) group and non-group contracts, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act (42 U.S.C.A. 301, et seq.), as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

B. "This Plan" is the part of the contract that provides benefits for health care Expenses.

C. "Primary Plan/Secondary Plan:" The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

D. "Allowable Expense" means a necessary, reasonable and customary item of Expense for health care; when the item of Expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

The difference between the cost of a private Hospital room and the cost of a Semi-Private Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

E. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

**III. Order of Benefit Determination Rules**

A. General. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

(1) The other Plan has rules coordinating its benefits with those of This Plan; and

(2) Both those rules and This Plan's rules, in Subsection B below, require that This Plan's benefits be determined before those of the other Plan.

B. Rules. This Plan determines its order of benefits using the first of the following rules which applies:

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(1) Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, Member or subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent; except that: if the person is also a Medicare beneficiary, Medicare is

(a) Secondary to the Plan covering the person as a Dependent; and

(b) Primary to the Plan covering the person as other than a Dependent, for example a retired employee.

(2) Dependent Child/Parents not Separated or Divorced. Except as stated in subsection (B)(3) below, when This Plan and another Plan cover the same child as a Dependent of different person, called "parents":

(a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

(b) If both parents have the same birthday, the benefits of the Plan which covered the parents longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in subsection (2)(a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

(3) Dependent Child/Separated or Divorced. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) First, the Plan of the parent with custody of the child;

(b) Then, the Plan of the spouse of the parent with the custody of the child; and

(c) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care Expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Dependent Child/Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care Expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph III subsection B(2) above.

(5) Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule (4) is ignored.

(6) Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:



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(a) First, the benefits of a Plan covering the person as an employee, Member or subscriber (or as that person's Dependent);

(b) Second, the benefits under the continuation coverage.

If the other Plan does not contain the order of benefits determination described within this subsection, and if, as a result, the Plans do not agree on the order of benefits, this requirement shall be ignored.

(7) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, Member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

**IV. Effect on the Benefits of this Plan**

A. When This Section Applies. This Section IV applies when, in accordance with Section III "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other plans" in (B) immediately below.

B. Reduction in this Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

(1) The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

**V. Right to Receive and Release Needed Information**

Certain facts are needed to apply these COB rules. We have the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts it needs to pay the claim.

**VI. Facility of Payment**

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

**VII. Right of Recovery**

If the amount of the payments made by Us is more than it should have paid under this COB provision, it may recover the excess from one or more of:



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A. The persons it has paid or for whom it has paid;

B. Insurance companies; or

C. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

## CLAIM PROVISIONS AND GENERAL PROVISIONS

### GP-10 CLAIM PROVISIONS:

**Notice of Claim**: When a claim arises, the claimant should notify Us or the Administrator of the Loss in writing. We will furnish a claim form or accept a proof of payment for covered services. This written notice of claim must be given within 20 days after commencement of any Loss covered by the Policy, or as soon as reasonably possible. If the claim form is not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing of Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

**Proof of Loss:** Written proof of Loss must be furnished to Us or to the Administrator. It must be furnished within 90 days of the Loss. Where the Policy provides for payments contingent upon a period of Confinement, these 90 days shall begin at the end of the period for which We are liable. If the claimant does not furnish proof within 90 days as required, benefits shall still be paid for that Loss if: (1) it was not reasonably possible to give proof within those 90 days; and (2) proof is furnished as soon as reasonably possible and, except in the absence of legal capacity, no later than one year after the end of those 90 days.

**When Benefits Are Paid:** We or the Administrator will make payment promptly upon receipt of due written Proof of Loss. Payment shall be made directly to the Insured Person or the provider of the service, as directed by the Insured Person in writing at the time of submitting Proof of Loss. If the Insured Person is deceased or, in Our opinion, is incapable of giving a valid receipt for payment, and if no claim has been made by a duly appointed legal representative, We shall have the option of making payment to either: (1) the Hospital or the person who actually incurred the Loss for which payment is due; or (2) a surviving relative of the Insured Person. Such a payment shall discharge Us from all further liability to the extent of the payment made.

**Appeal of Claim Denial:** If a claim is denied, the Insured Person will receive written notice giving the reason for the denial. If the Insured Person wishes to appeal the denial of the claim, such appeal must be submitted in writing within 60 days from the date of notice. The Insured Person must clearly state the reasons he believes the claim decision is incorrect.

### GP-20 GENERAL PROVISIONS:

**Assignment and Claims of Creditors:** Except as provided below, benefits under the Policy are not assignable unless as otherwise provided by law, benefits payments will be exempt from legal process for debts or liabilities of an Insured Person. You may direct Us to pay benefits to the person or institution on whose charges the claim is based. Any such payment that We make will fully discharge Us to the extent of the payment.



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**Calculation and Adjustment of Premiums:** We determine the premium for each Insured Person. We have the right to change premium rates on any premium due date by giving [60 days] advance written notice to You of such change. The premium rates may also be changed at any time the terms of the Policy are changed.

**Changes in Benefits:** Changes in the benefits of an Insured Person will apply only to Eligible Expenses or Losses incurred after the Effective Date of the change.

**Clerical Error:** Clerical errors made by Us in the issuance of Your Schedule of Benefits, Your Policy, or in record keeping for Your Policy will not afford You benefits or validate insurance for which You have not applied and paid the appropriate premium and been approved by Us. We have the right to offset or recover any overpayment of benefits made under the Policy from You.

**Conformity With Statutes:** Any provision of the Policy that is in conflict with the statutes of the jurisdiction in which the Policyholder is located on such date is hereby amended to conform to the minimum requirements of such statutes.

**Contract Changes :** The effective time for any changes made shall be 12:01 A.M. Standard Time at the address of the Policyholder.

**Amendment:** The Policy may be amended or changed at any time or times by written notification to the Policyholder and Us. Insurance provided by the Policy may be amended, changed or canceled without the consent of any Insured Person and without prior notice to him.

**Entire Contract:** The entire contract consists of the Policy, the Certificate, the application of the association, Your application form and any other amendments, endorsements, or documents requested and accepted by Us. No change in the Policy is valid unless approved by Our executive officer. Such approval must be signed by the officer and attached to the Policy. No broker, agent or producer can change or waive any provision of the entire contract or any of Our requirements.

**Grace Period:** You have a 31 day grace period for the payment of each premium due after the first premium. Your coverage will continue in force during the grace period unless You have given Us prior written notice of termination. If the premium is not paid by the end of the grace period, all such insurance will end as of the due date of such premiums, and no Expenses incurred during the grace period will be considered for benefits.

**Incontestability**: All statements made by You will, in the absence of fraud, be deemed representations and not warranties. No such statement will be used in defense of any claim or in a contest under the Policy unless a written copy has been given to You. Any misstatement or omission of information made on Your application form or on any other materials on which We relied to issue, change or increase coverage will be considered a misrepresentation and may be the basis of later rescission of coverage. After coverage for an Insured Person has been in force for two years during the Insured Person's lifetime, We do not have the right to contest that coverage, except for fraud or non-payment of premiums.

**Legal Proceedings:** No proceedings to obtain benefits under the Policy may be brought against Us until the expiration of 60 days after proper written Proof of Loss and any other documentation necessary to establish what benefits are due under the provisions of the Policy have been received by Us. No proceedings may be brought more than three years after proof is required to be filed.

**Misstatement of Age:** If the age of the Insured has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

**Payment of Premiums:** All premiums are paid to Us, or if We direct, to Our authorized representative. Premiums are due monthly, in advance, on the first day of each policy month, or if other than monthly,



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the first of the month of the payment period elected by You. Each monthly premium will pay for the insurance then in effect for a period of one month for Insured Persons. Each payment for a period greater than a month will pay for the entire period selected by You. Except as otherwise provided in the Policy, all coverage will terminate on the premium due date if premiums are not paid when due.

**Physical Exam and Autopsy**: We may require, at Our own expense, medical examinations of any person for whom a claim is made or make a request for an autopsy if not prohibited by law.

**Pronouns** – Whenever a personal pronoun in the masculine gender is used, it will be deemed to include the feminine also, unless the context clearly indicates to the contrary.

**Rescission:** A misrepresentation or omission in the application form or other documents provided to Us might be the basis for later rescission of all coverage of all persons insured under the Policy. Rescission voids all coverage as of the Effective Date and means that no benefits will be paid to any person for any claim submitted, whether or not such claim relates to the condition about which information was misrepresented or omitted. We will refund to You premiums paid after deduction for any claims paid out under the Policy by Us.

**Subrogation**: Upon payment of benefits for an Injury or Sickness, We will be subrogated to all rights of recovery an Insured Person may have against any third party responsible for such Sickness or Injury. This includes but is not limited to recoveries against such third party, against any liability coverage for such third party or against an Insured Person's automobile insurance in the event a claim is made under the uninsured or underinsured motorist coverage. Such right extends to all proceeds of any settlement or judgment; but is limited to the amount of benefits We have paid. You must: (1) do nothing to prejudice any right of recovery; (2) execute and deliver any required instruments or papers; and (3) do whatever else is necessary to secure such rights.

If We are precluded by law from exercising Our Subrogation Right, We may exercise Our Right of Reimbursement as defined by the Policy.

**Right of Reimbursement**

If an Insured Person incurs Expenses for Sickness or Injury that occurred due to the negligence of a third party:

(a) We have the right to reimbursement for all benefits We paid from any and all damages collected from the third party for those same Expenses whether by action at law, settlement, or compromise, by the Insured Person, the Insured Person's parents (if the Insured Person is a minor), or Insured Person's legal representative as a result of the Sickness or Injury; and

(b) We are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits we paid for that Sickness or Injury.

We shall have the right to first reimbursement out of all funds the Insured Person, the Insured Person's parents (if the Insured Person is a minor), or the Insured Person's legal representative, is or was able to obtain for the same Expenses We have paid as a result of that Sickness or Injury.

You are required to furnish any information or assistance or provide any documents that We may reasonably require in order to obtain Our rights under this provision. This provision applies whether or not the third party admits liability.

**Unearned Premiums Refund**: Upon the death of an Insured, unearned premiums shall be paid in lump sum within 30 days after the proof of the Insured's death has been furnished to Us.



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**Workers' Compensation**: This Policy is not a substitute for Workers' Compensation insurance and does not affect any requirement for Workers' Compensation coverage.

**D-10 DEFINITIONS**

**Accident:** means a sudden, unexpected and unintended event, which is identifiable and caused solely by an external physical force resulting in Injury to an Insured Person. Accident does not include a Loss due to disease or Sickness.

**Administrator:** means [ABC Administrator].

**Ambulatory Surgical Center:** means a licensed health care facility whose main purpose is the diagnosis or treatment of patients by surgery. It must: (1) admit and discharge the patient within the same working day; (2) be supervised by a Physician; (3) require a licensed anesthesiologist or licensed certified registered nurse anesthetist to administer anesthesia and remain during the surgery; (4) provide a post-anesthesia recovery room; and (5) have a written agreement with at least one Hospital for immediate acceptance of patients who develop complications.

It does not include: (1) a facility whose main purpose is performing terminations of Pregnancy; (2) an office maintained by a Physician for the practice of medicine; or (3) an office maintained for the practice of dentistry.

**Calendar Year:** means the period of time starting January 1 of a year; it ends on December 31 of the same year.

**Coinsurance Limit (Out of Pocket Limit):** The amount of money that You are required to pay from Your own funds for Eligible Expenses not paid by Us, such as Deductibles and Coinsurance; this does not include Expenses which are not payable by this policy.

**Coinsurance Percentage Payable:** means the applicable percentage specified in the Schedule of Benefits, which We will use in computing the amount payable when benefits are payable under the Policy after satisfaction of any Deductible Amounts.

**Complications Of Pregnancy:** means: (1) conditions requiring Hospital Confinement (when Pregnancy is not terminated) whose diagnoses are distinct from Pregnancy but are adversely affected by Pregnancy or are caused by Pregnancy, such as but not limited to: acute nephritis, nephrosis, cardiac decomposition, missed abortion and similar medical and surgical conditions of comparable severity; and (2) non-elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of Pregnancy which occurs during a period of gestation in which a viable birth is not possible. It does not include false labor, occasional spotting, Physician prescribed rest during the period of Pregnancy, morning sickness, hyperemesis gravidarum, elective cesarean section, pre-eclampsia and similar conditions associated with the management of a difficult Pregnancy not constituting a nosologically distinct complication of pregnancy.

**Confined/Confinement:** means being a Registered Bed patient as an Inpatient in a facility, on the order of a Physician, for Medically Necessary medical treatment for a period of no less than 18 consecutive hours.

**Coverage Period:** means the maximum length of time coverage is in force.



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**Deductible Amount:** means that amount specified in the Schedule of Benefits which is the initial out-of-pocket Expense paid by each Insured Person. Such Deductible Amount must first be satisfied by the application of Eligible Expenses which are subject to such Deductible Amount and which are incurred before any other Eligible Expenses will be payable under the Policy.

**Dependent:** means a Spouse or Dependent Child.

**Dependent Child(ren):** means Your unmarried Children, if any, who are primarily dependent upon You for support and maintenance. Each Child must be: (1) less than 19 of age; or (2) at least 19 years of age but less than 25 and be enrolled and attending as a full-time student at an accredited college, university, vocational or technical school. If the Insured Person is supporting a 19 year old Dependent child because of mental retardation or a physical handicap, coverage may be continued. We must receive written notice and proof of such conditions within 31 days of the child's 19th birthday. Thereafter, We may require, at Our expense, such proof once each year. "Children" means natural Children; stepchildren who are residing with You; legally adopted Children; and Children subject to Your legal guardianship.

**Effective Date:** means the date coverage under the Policy, or an insurance or benefit provision as the case may be, goes into force for an Insured Person. It is shown in the Schedule of Benefits.

**Eligible Expenses:** means: (1) treatments, services and supplies which a Physician recommends as Medically Necessary to treat a covered Injury or Sickness; and (2) charges which are Usual and Customary and are incurred by the Insured Person while he is insured under the Policy; and (3) charges which the Insured Person is legally required to pay.

**Emergency:** means a life-threatening medical condition resulting from Injury or Sickness that arises suddenly and requires immediate care to prevent permanent disability or jeopardy to life.

**Evidence Of Insurability:** means proof that a person is acceptable for insurance according to Our current underwriting rules. Such proof is at his expense unless otherwise stated.

**Expense:** means the Usual and Customary charges for Medically Necessary treatment, services and supplies. Such Expense shall not include any amount not customarily charged to persons without insurance.

**Experimental:** means those practices, treatments, drugs, and or therapies not accepted and approved by the American Medical Association, Federal Drug Administration and Health Care Financing Administration; not consistent with currently accepted medical practice; not legally obtainable; or not proven safe and effective.

**Home Health Agency:** means a public agency or private organization, or a sub-division of such an agency or organization, which: (1) is primarily engaged in providing skilled nursing services and other therapeutic services; (2) has policies established by a group of professional personnel (associated with the agency or organization), including one or more Physicians and one or more registered professional Nurses, to govern the services which it provides, and provides for supervision of such services by a Physician or registered professional Nurse; (3) maintains clinical records on all patients; (4) in the case of an agency or organization in any State, in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (a) is licensed pursuant to such law, or (b) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing; and (5) meets such other conditions of participation as are established under the Medicare program in the interest of the health and safety of individuals who are furnished services by such agency or organization.



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**Home Health Aide:** means a person who: (1) provides care of a medical or therapeutic nature; and (2) reports to and is directly supervised by a Home Health Care Agency.

**Home Health Care Plan:** means one that meets these standards: (1) a Physician must establish and approve the plan in writing; and (2) the plan must cover a condition that would otherwise require Confinement in a Hospital or convalescent nursing home.

**Hospice:** means care for an Insured Person who has a terminal illness resulting in a life expectancy of six months or less; the care must be recommended by the attending Physician.

**Hospital:** means a licensed institution which is legally constituted and operated in accordance with the laws pertaining to hospitals in the jurisdiction where it is located, and which meets all of the following requirements: (1) it is engaged primarily in providing medical care and treatment to sick and injured persons on an Inpatient basis at the patient's expense; (2) it provides 24-hour-a-day nursing service by registered, graduate Nurses; (3) it is under the supervision of a staff of duly licensed Physicians; (4) it provides organized facilities for diagnosis and for major operative surgery either on its premises or in facilities available on a prearranged basis; and (5) it is not primarily a clinic, nursing home, rest or convalescent home, extended care facility, Hospice or similar establishment nor, other than incidentally, a place for persons with mental or nervous disorders, the aged, alcoholics or drug addicts. Confinement in a special unit of a Hospital used primarily as a nursing, rest, or convalescent home shall be deemed, for the purposes of This Policy, to be Confinement in an institution other than a hospital.

**Immediate Family:** means: (1) the parent, spouse, brother, sister or children of the Insured Person; (2) a resident in the Insured Person's household, or the Insured Person's employer; or (3) any person related to the Insured Person by blood, marriage or legal adoption.

**Injury:** means bodily harm resulting from an Accident and is independent of all other causes.

**Inpatient:** means Confinement in a Hospital as a Registered Bed-Patient for a minimum of 18 consecutive hours for which room and board charges are made.

**Insured Person:** means the person who holds this Policy, and his eligible Spouse and Dependents who meet the Eligibility Requirements and have paid the required premium.

**Intensive Care Unit:** means a section, ward or wing within a Hospital which is separated from other Hospital facilities and: (1) is operated exclusively for the purpose of providing professional care and treatment for critically ill patients; (2) has special supplies and equipment necessary for such care and treatment which are available on a standby basis for immediate use; (3) provides room and board, and constant observation by registered graduate professional Nurses or other specially trained Hospital personnel; and (4) is not maintained for the purpose of providing normal postoperative recovery treatment or service.

**Loss:** means medical Expense sustained by an Insured Person that is covered by this Policy.

**Medically Necessary:** means a Confinement, service or supply that We determine meets each of these requirements: (1) it is ordered by a Physician for the diagnosis or the treatment of a Sickness or Injury deemed eligible within the language of this Policy; (2) for services or supplies, and the prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that omission would adversely affect the Insured Person's medical condition; (3) for Hospital Confinement, and the prevailing opinion within the appropriate specialty of the United States medical profession is that Inpatient acute care Confinement is necessary and any lesser level of care would adversely affect the Insured Person's medical condition; and (4) it is furnished by a provider with appropriate training, experience, staff and facilities to furnish that particular service or supply.



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**Nurse:** means a licensed registered graduate professional nurse (R.N.) or a licensed practical nurse (L.P.N.) who is under the direction of a Physician. The term nurse does not include the Insured Person, the Insured Person's Immediate Family, or the Insured Person's Employer.

**Outpatient:** means services rendered or charges incurred by a patient at a healthcare facility, including but not limited to, a Hospital, clinic, or Ambulatory Surgical Facility without a stay or admission of 18 consecutive hours or more.

**Overall Maximum Benefit Payable:** means the maximum aggregate amount of benefits payable under the Policy for an Insured Person for Eligible Expenses. It is shown in the Schedule of Benefits.

**Physical Medicine:** means treatment of a disease by physical agents such as: heat, cold, light, electricity, manipulation or the use of mechanical devices.

**Physician:** means a licensed practitioner of the healing arts who is practicing and treating within the scope and limitations of that license. The term Physician includes licensed Audiologist/Speech-Language Pathologist, Chiropractors, Dentists, Nurse Anesthetists, Optometrists, Podiatrists, Psychologist or Physician Assistant whose practice complies with the laws of Arkansas. The term Physician will not include the Insured Person, the Insured Person's Immediate Family, or the Insured Person's employer.

**Policy:** means the contract issued to the Insured Person providing the benefits described herein.

**Pre-Existing Conditions:** means any condition or complication thereof, that required medical treatment, advice, consultation, or Expense during the 36 months immediately before the Insured Person's Effective Date of insurance; or which produces symptoms within the 36 months immediately prior to the Insured Person's Effective Date of insurance. These symptoms must be significant enough to establish manifestation or onset by one of the following tests: (1) they would allow a Physician to make diagnosis of the disorder; or (2) they would cause a reasonable person to seek diagnosis or treatment.

**Pregnancy:** means normal pregnancy, normal childbirth or elective cesarean section.

**Prescription Drugs:** means: (1) a legend drug; (2) injectable insulin prescribed by a Physician; (3) a compounded drug of which at least one part is a legend drug; or (4) any other drug that, under state law, may only be dispensed upon the written prescription of a Physician. It does not include an oral contraceptive for prevention of Pregnancy.

**Professional Review Organization:** means or refers to an organization selected by Us that provides a program of medical review services under Physicians, Nurses and record technicians.

**Registered Bed-Patient:** means an individual who, while Confined to a Hospital, is assigned to a bed in any department of the Hospital, and for whom a charge for room and board is made by the Hospital.

**Semi-Private Room:** means a room with at least two beds in a Hospital.

**Semi-Private Room Rate:** means: (1) the facility's most common daily charge for room and board for a Semi-Private Room; or (2) if the facility does not have Semi-Private Rooms, 80% of its daily charge for room and board for its lowest rate private room.

**Sickness:** means an illness, disease or infection, except Pregnancy. It includes Complications of Pregnancy only: (1) during Confinement in a Hospital; and (2) if conception occurred after the Insured Person's Effective Date. Complications of Pregnancy will be automatically included if birth occurs at least 270 days after the person's Effective Date. With respect to Dependent Children who automatically



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become insured under the Policy at birth, the term "Sickness" shall also include medically diagnosed congenital defects and birth abnormalities.

**Skilled Nursing Facility:** means an institution, or distinct part of an institution, which is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care and treatment for persons convalescing from Injury or Sickness and: (1) is approved by and is a participating Skilled Nursing Facility of Medicare; (2) has organized facilities for medical treatment and provides 24-hour-a-day nursing service under the full-time supervision of a licensed Physician or of a registered graduate professional Nurse; (3) maintains daily clinical records on each patient and has available the services of a licensed Physician under an established agreement; (4) provides appropriate methods for dispensing and administering drugs and medicines; (5) has transfer arrangements with one or more Hospitals, a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group including at least one licensed Physician; and (6) is not, other than incidentally, a rest home for the aged, or a place for the treatment of mental disease, drug addiction or alcoholism.

**Sound Natural Tooth:** means a tooth that is natural, whole, vital and free of disease.

**Spinal Manipulation Or Adjustment:** means the treatment of: (1) of any bodily ailment, complaint, pain or Injury, including rehabilitation or treatment related to loss of bodily part, peripheral nerves, spinal cord or musculoskeletal or other soft tissue Sickness or Injury; and (2) by various physical, manual or mechanical means, including the use of heat, cold, light, sound, water, exercise, massage, manipulation, electric current or any other Physical Medicine service or procedure.

**Spouse:** means Your lawful spouse, who is not legally separated from You, and is under age 65 at the time of application. It does not include a common law spouse.

**Total Disability Or Totally Disabled:** means the Insured Person is prevented by reason of Injury or Sickness from engaging in his own occupation for wage or profit and any occupation to which he is suited by talent or education. A Dependent is considered to be totally disabled when he is prevented by reason of Injury or Sickness from engaging in all normal activities of a person of like age and sex in good health.

**Usual And Customary:** means a charge which is: (1) made by a Physician or supplier of services, medicines, or supplies; and (2) the customary charges made by others rendering or furnishing such services, medicines or supplies within an area in which the charge is incurred for Sickness or Injury comparable in severity and nature to the Injury or Sickness being treated. The term "area" as it would apply to any particular service, medicine or supply, means a county or such greater area as is necessary to obtain a representative cross section of level of charges.

**We, Us, or Our**: means Markel Insurance Company.

**You, Your, or Yourself:** means the Insured Person.



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